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DR. WILLIAM J. TIFFANY, *Commissioner*

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MARY TODD LINCOLN

A Psychiatric Study

BY LIEUT. JAMES A. BRUSSEL, M. C.
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Frequently we are at a loss for predisposing and precipitating factors in establishing etiology in a given psychiatric case. Organic causes are lacking, heritage is clear, and the patient's past and present periods of life are free of maladjustment or unfavorable situations that might precipitate a mental illness. Occasionally, however, a syndrome presents itself that is replete with etiological factors, running the gamut from congenital defects to adverse living conditions and complicating trauma. Under such conditions, establishing the diagnosis becomes a difficult problem.

Such is the picture when the story of Mary Todd, wife of the sixteenth president of the United States, is unfolded. Adding to the clinical confusion, is the vague autopsy report, the meningitis following trauma which occurred late in life, plus the pitiful psychological insults suffered within a few years. Here was a woman—rudely uprooted from backwoods obscurity and suddenly made the most prominent feminine figure in the America of her day—who lived at the White House during the most difficult years the capital had ever known, who had the unhappy faculty of drawing unfavorable comment from all sides, and who witnessed the deaths of her two sons and the grisly murder of her husband. There are many who would say that this explained her psychosis. But there are other factors that cannot be excluded in a critical appraisal of her history and an evaluation of events.

Case Study

Family History—The family stock on both sides sprang from sturdy pioneers who assisted in the early building of the country, shaping its policy, fighting its battles. The paternal grandfather, Levi Todd, settled in Kentucky where his large estate adjoined that of Henry Clay. The maternal grandfather, Major Robert Parker, a veteran of the Revolution, was a first cousin of Levi Todd. Thus, the patient's antecedants were blood relatives. The father, Robert Smith Todd, was a college-trained man who, though admitted to the bar, preferred security, as clerk of the Fayette Circuit Court, to the uncertainty of practice. Following his marriage to the patient's mother, he kissed his bride and departed at once to serve in the War of 1812. He returned a year later to take up domestic life with the woman who was at once his wife and cousin. He was described as

"impetuous, high-strung and sensitive," while his spouse, Eliza, was "placid and of a sunny disposition." There were 13 siblings, six, including Mary Todd, by the first wife, and the others by the second wife whom Robert Todd married in 1826, following the death of Eliza at the early age of 31. Of the patient's brothers and sisters, none are recorded as having suffered from organic disorders, or as having had psychological defects; nor were their histories unusual.

Personal History—Whether the organic process that was later to widen sulci and shrink convolutions was congenital or not, there was nothing at birth on December 13, 1818 or during early life to indicate that the brain beneath the well-formed skull was anything but normal. Mary has been pictured as a beautiful baby, learning to walk and talk at the usual times, laughing, playing and amusing herself in and out of the large, well-appointed house that stood in the midst of Kentucky's rustic charm. The Todd household offered her all the advantages of the well-to-do. She ate, slept, and dressed well. Parents and relatives showered her with costly gifts and fine clothes. Her playmates were numerous, and she mingled well. She attended the best schools and academies. She was versed in cooking, languages and the arts. And she was an apt pupil.

Early in life, however, she showed manifestations of the fire and drive that were later to amaze the country. She regaled her brothers, sisters and companions with lurid stories born of a wild imagination; tales that were punctuated with "fire and hell and graveyards and death." She not only met life toe to toe, she attempted to shape it and twist it to her own egocentric whims and desires. Her girlhood was more than zestful—in an era when Mr. Godey depicted the well-bred maiden as shy, demure and reserved—it was a procession of flaming fervor and passion. Unlike others of her age, she became interested in politics at a time when she should have been preoccupied with tag and hide-and-seek. Her likes and dislikes were no tepid half-measures. She bitterly hated the Democrats and ardently followed the Whigs, with sound reasons why she had enlisted in the latter party. At the age of 14, she dashed up on the lawn of Senator Henry Clay. She was astride her white pony which she controlled masterfully. "Mr. Clay," she said, causing the horse to rear up on its hind legs, "my father says you will be the next President of the United States. I wish I could go to Washington and live in the White House."

She quoted classics with precocious ease and skillful oratory. She sewed with rare dexterity. She argued the most minor points in the Bible. She composed impromptu poetry at the drop of a hat. Once she jumped at a blue jay, chanting:

"Howdy, Mr. Jay. You are a tell-tale-tell.
"You play the spy each day, then carry tales to hell."

She danced well and attended many gay parties. She grew into womanhood beautiful and well-formed, a true "belle of the town." Life was packed with excitement, thrills and new sensations which she met, according to one friend, with abundant liveliness, vibrant to sensations. This friend, Margaret Stuart Woodrow, described Mary in a particularly keen, analytical manner. "She was very high strung, nervous, impulsive, excitable, having an emotional temperament much like an April day, sunning all over with laughter one moment, the next crying as though the heart would break." Her sister writes: " . . . now and then she (Mary) could not restrain a witty, sarcastic speech that cut deeper than she intended . . . She was impulsive and made no attempt to conceal her feeling; indeed, that would have been impossible, for her face was an index to every passing emotion." And these traits, we may add, were the cause of her very undoing in years to come. One biographer wrote, "Brilliant, vivacious, impulsive, she possessed a charming personality marred only by a transient hauteur of manner and a caustic, devastating wit that cut like the sting of a hornet."

The courtship and marriage of Mary Todd and Abraham Lincoln formed a strange affair. To her family and friends, it was nothing less than amazing that this handsome, brilliant girl should even tolerate the tall, lanky, ungainly country lawyer who had little in material assets and less in promise for the future. Lincoln shrewdly appreciated the inequality between them. He felt that he was not worthy of this "beautiful, dashing, gay and attractive" creature who was the "catch of the day." For two years, he vacillated between proposal and doing what he thought was noble and right by blotting her name from his mind. In fact, during this time he developed a neurosis—diagnosed as "hypochondriasis"—and required the constant supervision of a physician. Likewise, Mary's sparkling, spontaneous wit and her smooth grace, made the awkward and bashful bumpkin shy and afraid. So obscure is the final settlement of the question, that there is no record of an engagement date. Nevertheless, on November 4, 1842, Mary Todd became Mary Todd Lincoln.

It was a peculiar mating. Lincoln frequently referred to the union as "the long and short of it." The wife, keenly sensitive of the difference in height, never permitted a picture or a photograph to be made of them as a couple. There were differences other than physical. She was impulsive in speech and dynamic in word; he was cautious and slow of tongue. He had come from the lower class, she boasted of her patrician extraction. In fact, on her wedding night, she expressed vexation over arranging for

the "plebians." And time did not improve the couple's relations. She became more explosive at increasingly frequent periods, her uncontrollable outbursts before important personages causing her husband no little embarrassment. In contrast, history shows how more and more the husband developed patience, tolerance and self-control. They both were ambitious; but Lincoln hid his political aspirations behind a mask of melancholy, while Mary plainly showed her intense anxiety and eagerness for advancement.

She was always on the alert for the latest dictum of society, and she constantly adjured her husband to watch his dress more carefully. When she eventually managed to encase his long, lean fingers in white gloves at evening functions, it was a battle well won. When he went to Congress in 1846, her gay spirits knew no bounds. She had ambitious plans for the future. She had tasted the delights of society at the capital and now burned to be its mistress. Lincoln's failure to be reelected was a severe blow to her hopes. But she egged him on to advance himself. She made him pull wires, interview influential politicians and write congressmen to obtain some Federal post by appointment. It is said that Lincoln was pleased when he did not land such a job; and he eagerly returned to practice law in Springfield.

In 1843, Mary Lincoln gave birth to Robert Todd, in 1846 to Edward Baker who lived but four years, and in 1850 to William Wallace (Willie) who died in 1862. Thomas, nicknamed "Tad" and a favorite of the president, was born in 1853. Despite a deformed palate and lisp, he was a bright and humorous child. He survived less than two decades, dying during the most turbulant period the household had ever known. Biographers agree that his loss materially aggravated the mother's mental state.

Psychosis—The date of onset is unknown. Some place it from birth, others after marriage. It is definite, however, that overt symptoms appeared with alarming rapidity during the marital period. Lincoln was perfectly cognizant of his wife's explosive nature, her irritable and impatient attitude, and her interfering and prying tendencies. Mary Todd Lincoln knew he was aware of her weaknesses, knew she imposed on his patience and amiability, and realized that her tantrums and stormy outbursts were sources of humiliation and annoyance to her husband. Yet he met each episode with kindliness and tolerance; he apologized and explained, over a period of years, every time her unsavory and unwise behavior brought anguish and disfavor upon the White House.

In her early twenties, Mary Todd Lincoln suffered violent headaches, a complaint which followed her to her grave. Associated with these migrainous attacks, were uncontrollable rages. She frightened tradesmen,

delivery boys and servants with vitriolic tongue-lashings. Her sudden and wild outbursts of temper would leave her weak, helpless and trembling. After each attack she would suffer pangs of remorse and guilt, and would be mortified that "she had made a fool of herself again." When one man complained to Lincoln of one such scolding, the latter dryly commented that the gentleman should be able to survive for 15 minutes what Lincoln had stood for 15 years. And there are indications that he stood more than verbal onslaughts at times. Neighbors tell of an incident in which it is alleged that his wife chased Lincoln out of the house with a broomstick. Certainly it is a fact that—while he sometimes laughed at her outbursts, a dangerous procedure before such an infuriated woman—he often picked up one of the children and deliberately left the house until peace was restored. On one occasion it is said she poured a bucket of water on his head from a second-story window while he waited to be admitted to the house. But even placid Abraham lost control of himself once in a while, under pressure of her constant nagging; and he once pushed her from the house into the street, screaming after her, "You make the house intolerable, damn you, get out of it!" There were witnesses to this incident. How many others had occurred in which the husband had resorted to profanity and the use of his hands? Sandburg says: "Domestic flare-ups, nerve-snappings, come to all couples; perhaps to these two they simply came more frequently and more violently."

With passing years, Lincoln's prestige grew; and there were more and more social functions, political rallies, parades and dinners. They served to whet Mary's appetite for eminence, distinction and fame. To her insatiable lust for the pinnacle of social success, the husband was in no small measure indebted for his rise. In the calm interludes of her illness, she exerted a strong influence over him. She was his teacher in diction, manners and appearance. He was an apt pupil and profited well by the lessons. He was indifferent and slow to move, but was quickly stirred when prodded by his restless mate. When he was depressed, her tireless tongue whipped him out of his dejection.

She was never again to experience the high spirits and jubilation that followed the nomination and election of Abraham Lincoln to the presidency. She had suddenly become "somebody." Her words were eagerly sought by reporters, women hungrily waited for the fashion criticism to fall from her lips, and her ever-swelling ego basked in the warmth of such compliments as she read in the New York Herald, ". . . she is especially gracious and entertaining," and able to inject "brilliant flashes of wit and good nature" into political conversation.

Once in the White House, the couple probably had little if any time for sexual contact. Night after night, the president sat up until the small hours of morning, occupied with affairs of state. They slept in separate chambers. Cabinet officers, office-seekers, congressmen, visitors, committees, in fact every one from beggar to banker, formed a steady queue at the door. It began at eight in the morning and lasted until after midnight, so that Lincoln had few moments with his family. Furthermore, he was bowed down by the war and dissolution of the Union. Mary Todd Lincoln, however, experienced no overt pangs of sexual frustration. She was too busy elsewhere. She was launched on one of her many extravagant shopping tours, or shouldering her unwanted way into politics and governmental management, or off on some luxurious week-end excursion to a fashionable resort. As long as she was unchecked, she was happy. Her lack of concern over any embarrassment was appalling. She was indifferent to sarcastic comment in the papers concerning her many blood relatives who were prominent officers in the Confederate Army. For every adverse criticism in print, she had a curl of the lip and a nonchalant shrug of the shoulder. Flattering or not, these notices were publicity; and publicity was a drink which quenched her thirst for renown.

And what of definite psychiatric symptomatology? Were there hallucinations and delusions? Anamnesic data from different sources give revealing light on this subject. In 1861, when the Confederate Army threatened Washington, a southern woman in the Capital wrote to the New Orleans Delta: "Mrs. Lincoln, a few nights since, heard whisperings in the hall in front of her room; she rose from bed, dressed, and sat up the remainder of the night, watching for the Southern Army to blow up the White House." Earlier, James Gourly, a neighbor, wrote: "She was gifted with an unusually high temper and that usually got the better of her. She was very excitable and when wrought up had hallucinations." Says Sandburg: "Under the progression of her malady, the hammering wear and tear of the repeated periods of hysteria and hallucinations, there was a fading of a brightness seen in her younger years. The days in which she neither felt nor looked well increased. Her sudden angers interrupting a smoothly moving breakfast, her swift wailings in the dark quiet of night time when fears came to possess her—these brought long thoughts to her husband." Henry Villard, the correspondent, told of a story he heard from the man who was sent to escort the president-elect to his train when leaving for Washington. The man related that, at the Chenery House, he saw Mary Lincoln lying on the floor, "raging and convulsive, her apparel disordered, moaning and groaning."

Lincoln himself showed deep insight into his wife's condition when, at the time of Willie's death, he begged the woman to control her sorrow. He led her to a window and said, "Mother, do you see that large white building on the hill yonder? Try to control your grief, or it will drive you mad, and we may have to send you there."

From various and sundry reliable sources, are furnished pertinent appreciations of the illness, the woman, and her state of mind. For example, Lincoln's journey to Washington for his first inauguration had to be clandestine. One of the arrangers of the secret journey, A. K. McClure, wrote: "The greatest difficulty we had on that occasion was to prevent Mrs. Lincoln from creating a scene that would have given publicity to the movement. I thought her a fool." Again, Murat Halstead of the Cincinnati Commercial wrote: "The wife (Mrs. Lincoln) is a fool—the laughing stock of the town, her vulgarity only the more conspicuous in consequence of . . . her damnable airs." Another reporter, describing a White House reception, said, " 'Old Abe' shakes their hands cordially, smiles graciously, addresses them familiarly, and we pass on to Mrs. Lincoln, who, nearer the center of the room, maintains her position with the steadiness of one of the Imperial Guard." John Hay, the faithful secretary of the president, referred affectionately in his diary to Lincoln as "Tycoon" and "The Ancient," while Mrs. Lincoln was dubbed "Hell-cat" who could become more "Hell-catical by the day." In fact, Hay and Nicolay, the other secretary, soon found a hotel more conducive to comfort and peace than the White House.

Mary Lincoln's interference in presidential matters, political and official affairs was brazen, bold and endless. When Abraham Lincoln became the chief executive, her fondest dream of being the first lady of the land had come true. To her, the event was not a summons to comfort and help the president; it was an omen that she was to be a cabinet member without portfolio, an adviser, and associate first magistrate. She lost no time in voicing her likes and dislikes, her choice in appointments, her beliefs and principles. Perhaps her "finger in the pie" would have passed unnoticed had she confined her spoken opinions to the parlor and boudoir. But she blurted out her flatteries and derogations alike before assemblies and crowds. Was there any phrase more embarrassing to the president than her terming Seward, secretary of state, a "dirty abolition sneak?" Not only did Mrs. Lincoln openly and passionately regard much of the work of the day as her business, as well as the president's, but she deemed it more important than the simple, natural tasks she should have undertaken as a wife. Heterosexual duties she often avoided as a "reprimand" to her husband who did not always fall in step with her wishes. For ex-

ample, Senator Fessenden, whose cause she never ceased championing with unflinching vehemence, wrote to his family: "One morning in came Lincoln sad and sorrowful. 'Ah!' said he, 'today we must settle the case of Lieutenant ————. Mrs. Lincoln has for three nights slept in a separate apartment.' "

She dabbled in squabbles over which of her relatives should have minor appointments. During the critical era of the late summer of '62, while her husband was trying to hold his cabinet together, she wrote on October 4 to publisher Bennett of the New York Herald who bellowed daily for a cabinet shake-up: "From all parties the cry for a 'Change of Cabinet' comes. I hold a letter, just received from Governor Sprague in my hand, who is quite as earnest as you have been on the subject. Doubtless if my good patient husband were here instead of being with the Army of the Potomac, both of these missives would be placed before him, accompanied by my womanly suggestions, proceeding from a heart so deeply interested for our distracted country. I have a great terror of strong-minded ladies, yet if a word fitly spoken and in due season can be urged in a time like this, we should not withhold it. As you suggest, the cabinet was formed in a more peaceful time, yet some two or three men who compose it would have distracted it. Our country requires no ambitious fanatics to guide the helm and were it not that their counsels have very little control over the president, when his mind is made up as to what is right there might be some cause for fear."

What an unsurpassed token to her narcissism, and what ambivalent manifestations. These factors, attested by the patient herself, enter strongly into the diagnostic consideration with no little importance. That Mrs. Lincoln was not above the basest treachery, regardless of the embarressment to her husband, is revealed by the scandal that was caused when the Herald published excerpts of a presidential message before it reached Congress. An investigation was instituted. One Henry Wikoff admitted to the congressional committee that he filed the purloined paragraphs at the telegraph office. He was placed in solitary confinement during the inquiry. Ben P. Poore wrote:

"It was generally believed that Mrs. Lincoln had permitted Wikoff to copy those portions of the message that he had published, and this opinion was confirmed when General Sickles appeared as his counsel. The general vibrated between Wikoff's place of imprisonment, the White House, and the residence of Mrs. Lincoln's gardener, named Watt. The committee finally summoned the general before them and put some questions to him. He replied sharply and for some minutes a war of words raged. He narrowly escaped Wikoff's fate, but, finally, after consulting books of evidence,

the committee concluded not to go to extremes. While the examination was pending, the sergeant-at-arms appeared with Watt. He testified that he saw the message in the library, and, being of a literary turn of mind, perused it; that, however, he did not make a copy, but, having a tenacious memory, carried portions of it in his mind, and the next day repeated them word for word to Wikoff. Meanwhile, Mr. Lincoln had visited the Capitol and urged the Republicans on the committee to spare him disgrace, so Watt's improbable story was received and Wikoff was liberated."

Other comments ran similarly. Henry Villard placed his finger diagnostically on Mary Lincoln's weakness. "She allowed herself to be approached and continuously surrounded by a common set of men and women whose bare-faced flattery easily gained controlling influence over her." Thus, he accounts for the Wikoff intrigue. William H. Russell of the London Times wrote: "The lady is surrounded by flatterers and intriguers, seeking for influence or such places as she can give!" In a lengthy and shrewd analysis, he said that the rise in position from the wife of an unknown rural lawyer to the station of first lady of the land was a sudden transition, from obscurity to power, which filled her with ambition and a zeal to dominate.

Indiscreetly, her letters and conversation constantly exposed White House details. To her cousin Lizzie, she wrote of appointments; to journalist Halstead (who privately dubbed her silly and vain), she confided how "comforting was the knowledge that General Banks would *not* be a cabinet member." She gradually developed a reputation of occupying herself in appointments. She told Hernden that her husband relied greatly on her wisdom and knowledge of human nature—"often telling me, when about to make some important appointment, that he had no knowledge of men and their motives." As one correspondent expressed it: "She looks as if she made the excellent Abe stand around." Even the tolerant and patient husband, when asked why he looked "powerful weak" at breakfast one morning, (when his wife was not present), once blurted out, "Whoever marries into the Todd family gets the worst of it!" When she interceded in behalf of a condemned soldier, sentenced to be shot, McClellan referred to her as "Mrs. President," a title that followed her for years.

In 1864, with reelection and a fresh wave of Union victories, newspapers gave less space to her whims and fancies. Many malicious pens were otherwise occupied. Thus, at this time, when she dismissed a White House doorman after 30 years of continuous service, little notoriety was given to the occurrence.

Mary Lincoln was a perfect example of ambivalence. She could be as tender and solicitous as she could be vicious and vindictive. Her visits to the hospitals were numerous. She spent hours ministering to the sick, wounded and disabled. She had a horror of physical suffering, since she knew too well what pain meant. Yet, there are many observers who felt that her errands of mercy were exhibitions, egocentric parades to prove to a watchful and critical public that she was capable of generosity and kindness. Her tireless caring for her boys was the quintessence of devoted motherhood. Nevertheless there was something of the ferocious jealousy of a jungle tigress who guards her cubs. Her children were pigmy images of her ego, silhouettes of herself, that had to be perfect and unscathed by any marring external influence. She was modelling likenesses of Mary Todd Lincoln to carry on when she was no more. Consequently, when she had had two sons taken from her, she bitterly resolved to cling to the other two.

She remained oblivious to the journalistic sneers concerning her 22-year-old Robert who sat "safe and snug in Washington while others died for the preservation of the Union." Not so the president. He was mortified, and wished to set a good example, especially since the unpopular draft laws had had such disastrous results. After tears, pleas, arguments and stormy verbal sessions, he arranged to have Robert appointed as a captain to the relatively safe post of aide to Grant. Still Mrs. Lincoln had her wish. Robert remained at Harvard and was graduated; and only in the last three months of the war was Lincoln able to place his boy in uniform by promising the distraught mother to keep the lad protected from immediate danger!

Mrs. Lincoln's narcissistic lavishness is history. She thrived on adulation, required attention, revelled in adornment, and was sensitive to snubs. The penumbra of limelight was utter darkness to a conscious drive born of unconscious inferiority. She would be outdone by no one, even if the race meant financial ruin for her husband, and regardless of the subterfuge or chicanery she had to employ. Reliable anamneses on this subject are enlightening. The New York Express protested her lavish shopping trips, dashing through lines of soldiers with "her driver and postillion in livery, in a glaringly labelled carriage to denote who is a passer!" Her unwillingness to be surpassed by another was exemplified in the Dayton Empire. "Mrs. Lincoln has got a new French rig with all the posies, costing $4,000, Miss Chase sees her and goes one better by ordering a nice little $6,000 arrangement, including a $3,000 love of a shawl," etc., etc. An "open letter" in a newspaper, at a time when war deaths ran appallingly high, asked her "to abandon for the time the frivolous, childish chatter. . . .

Shall the inanities of a ball room and theater be now the order of your life, when there is scarcely a family in our midst (not) suffering the pangs of mortal bereavement?" Mrs. Keckley, the mulatto seamstress in whom Mary confided, reported that in 1864 the mistress of the White House voiced misgivings concerning the election. The dressmaker asked Mrs. Lincoln why she was so worried. The latter replied, "I have contracted large debts, of which he knows nothing, and which he will be unable to pay if he is defeated." Asked what these debts were, Mrs. Lincoln answered: "They consist chiefly of store bills. I owe altogether about $27,000, the principal portion at Stewart's in New York. . . . I must dress in costly materials. The people scrutinize every article that I wear with critical curiosity." She was asked if the president knew of her financial obligations. "God, no! (a favorite expression of hers) and I would not have him suspect. The knowledge would drive him mad!"

But she continued to bask in every form of extravagance, a genuflecting worshipper at the shrine of her own ego. She thrilled at the complimentary salute of 15 guns at West Point; for her son's graduation from Harvard, she purchased a few "knick-knacks" such as a $5,000 shawl and a $3,000 pin. Likewise, she demanded (and received) from the harassed president many favors and grants for her numerous relatives on the Confederate side, utterly unmoved by the adverse comments in the newspapers that must have, at least, caused the chief executive no little discomfiture. Psychologically, her ruthless ego shoved and elbowed its way through a forest of restrictions, trampling ethics, diplomacy and decency beneath its rude feet.

She was pleased, therefore, and not irked at journalistic descriptions of her extravagances when, during times of national sacrifice and self-denial, such notices should never have been printed. The New York Herald seldom missed a day in reporting some social affair or trip, sparing no superlatives in expounding on her costly baggage, accommodations, finely arrayed companions, entertainment, equipage, etc. Mrs. Lincoln fairly purred when the Herald said she "looked like a queen in her long train and magnificent coronet of flowers." This probably prompted her ill-advised statement that she, "like Queen Victoria and other personages, must meet the fate of being gaped at." Mary Lincoln's regal manner was a bitter pill for the warmest supporters of the president to swallow. Even Vanity Fair, a staunch admirer of Lincoln, ridiculed the showy entrance of his wife into Long Branch (a popular New Jersey resort of the day), with a ludicrous front-page cartoon of the lady as a queen.

Her smoldering jealousy and limitless ability to hate with flaming fury were topics of discussion for years. Her abhorrence of Secretary Seward

was venomous and bitter. She never permitted her carriage to pass his door. Yet, she was required to swallow this hatred when the subject of Lincoln and other women became associated in her warped mind. Many examples reveal the endless bounds to which her insane jealousy—a projected inability to adjust to heterosexualism—would run. Ordinarily, she would not attend a function where Seward was also scheduled to be a guest. However, if other women were to be present, Mrs. Lincoln would come, her narrowed eyes steadily watching the other female guests. She disliked the presidential attendance at Sanitary Fairs because "thousands of women crowded about him." She sanctioned his appearance at these events only when she was his companion. Since the first inaugural ball of George Washington, tradition had dictated that the president and his wife should not escort each other in the grand march. Mrs. Lincoln changed that. The presidential arm would support Mary Todd or no one else. Yet, at the inaugural ball of 1865, the old Seward-ego conflict raised its ugly head into consciousness. She was forced to entrust the president's care to another woman while she marched beside Senator Fessenden whom she was advancing as a substitute for Seward.

In 1864, when Lincoln visited Grant's army, the wives of the general and the president rode together in an army ambulance. No woman was allowed at the front, but an officer inadvertently revealed that Mrs. Griffin, wife of General Griffin, had a special permit from Lincoln to remain in the forward line. Writes Sandburg of this occasion:

"Swift as a cat leap, Mrs. Lincoln: 'What do you mean by that, sir? Do you mean to say that she saw the president alone? Do you know that I never allow the president to see any woman alone?' Badeau (the officer) saw the face of a woman boiling with rage. He tried smiling toward this face, to show there was no malice. Badeau's smile was timed wrong. 'That's a very equivocal smile, sir,' he now heard. 'Let me out of this carriage at once. I will ask the president if he saw that woman alone.' Badeau and Mrs. Grant tried to soothe and quiet a woman later and definitely found to be mentally diseased. They failed. Mrs. Lincoln ordered Badeau to have the driver stop, and Badeau hesitating, she thrust her arms past him and took hold of the driver. By now, however, Mrs. Grant was able to coax Mrs. Lincoln to be still and wait. As they alighted at the reviewing ground, General Meade walked up, paid his respects to Mrs. Lincoln, escorted her away, later returning her with diplomatic skill, Mrs. Lincoln informing Badeau, 'General Meade is a gentleman, sir. He says it was not the president who gave Mrs. Griffin the permit, but the secretary of war.' "

Again, at another army review a short time later, Sandburg reports: "Mrs. Lincoln and Mrs. Grant arrived . . . in time to see Mrs. Ord riding near the president in the reviewing column, though equally near her husband, who was the immediate commander of the troops under review. Seeing the ambulance drive in on the parade line, Mrs. Ord excused herself with 'There come Mrs. Lincoln and Mrs. Grant—I think I had better join them.' The accounts of Barnes, Porter and Badeau as to what then happened agreed that there were embarrassing moments and bitterly pathetic exhibitions. . . . It seemed, however, that Mrs. Lincoln furiously exclaimed: 'What does this woman mean that *he* wants *her* by the side of *him*?' She went into a frenzy that mingled extravagant rage and drab petulance. 'All that Porter and I could do,' wrote Badeau, 'was to see that nothing worse than words occurred.' They feared some wild scene of violence enacted before the troops so calmly standing at 'present arms.'

"One outburst flung itself at Mrs. Grant: 'I suppose you think you'll get to the White House yourself, don't you?' Mrs. Grant kept cool, saying she was quite satisfied with her present position, that it was far greater than she had ever expected to attain. Mrs. Lincoln: 'Oh! you had better take it if you can get it.'

"Then the slings of reproach were sent at Mrs. Ord, with Mrs. Grant quietly and at some risk defending her friend. A nephew of Secretary Seward, a young major and a member of General Ord's staff, a joker, rode alongside and blurted out with a rich grin: 'The president's horse is very gallant, Mrs. Lincoln. He insists on riding by the side of Mrs. Ord.' This of course helped no one. Mrs. Lincoln cried, 'What do you mean by that?' and young Major Seward at once had horse difficulties and shied away in a crazy gallop. When the review ended . . . Mrs. Lincoln in the presence of a group of officers, according to Badeau, hurled vile names at Mrs. Ord and again asked Mrs. Ord what she meant by following the president. Enough of this sent Mrs. Ord into tears. . . . Mrs. Lincoln stormed till she spent her strength."

Later, the presidential party returned by boat; and Captain Barnes, who refused to blame Mrs. Ord, found it uncomfortable on board because Mrs. Lincoln made life unbearable for him. Through Mrs. Grant, he learned that Mrs. Lincoln bade him go ashore. Later he saw the president and said: ". . . he made me sit down and we talked for a while—mainly, I could see, to put me at my ease." Barnes felt himself drawn closer to the president because of the embarrassing scenes produced by a woefully diseased brain. He believed Lincoln's melancholia at the time was partly caused by the behavior of Mrs. Lincoln. The off-stage whisper was now

"crazy woman," though Barnes was more humane. "She was at no time well; the mental strain upon her was great, betrayed by extreme nervousness approaching hysteria, causing misapprehensions, extreme sensitiveness as to slights or want of politeness or consideration." A gentleman's description of a paranoid formulation! But he was not alone in his opinion.

Badeau wrote of the return trip: "Mrs. Lincoln repeatedly attacked her husband in the presence of officers because of Mrs. Griffin and Mrs. Ord . . . he (Lincoln) bore it as Christ might have done . . . with supreme calmness and dignity . . . he called her 'mother' . . . pleaded with eyes and tones, endeavored to explain or palliate the offenses of others, till she turned on him like a tigress; and then he walked away," covering his face so that others might not see the emotion he felt. Badeau reported that Mary Lincoln once rebuked Mrs. Grant with, "How dare you be seated until I invite you?" When the boats docked, it chanced that Mrs. Lincoln's gunboat was one ship removed from the pier by Mrs. Grant's vessel. The proud wife said she would not disembark until her boat was next to the dock. As the river was choked with naval craft, it required no little maneuvering to re-arrange the boats. But it was done!

Perhaps her love of creating ghoulish tales as a child presaged the later superstitions and interest in spiritualism. Never during their career of marriage could Lincoln permit his wife to be alone during a thunderstorm, because he knew that she was struck with terror by the faintest rumble of the heavens. After Willie's death, the sorrowing mother became easy prey of every fakir who dabbled in the "beyond." On the same day that the Emancipation Proclamation was released to the world, Mrs. Lincoln drove to Georgetown to consult a Mrs. Laury, a spiritualist who made "wonderful revelations" to Mary concerning her son Willie, and also "about things on earth." Some of these revelations included the statement that the cabinet members were all hostile to the president, working for themselves, and that they would have to be dismissed and others called to his aid before he could attain success. As a result of these seances, Mary Todd Lincoln believed in communication with the dead and thought she could see apparitions of the departed. One night, returning from a seance, she cried: "He lives!" (Willie). "He comes to me every night and stands at the foot of my bed, with the same sweet, adorable smile he always had." Dreams born of wishful thinking or frank hallucinations?

An article appeared in the Boston Gazette on April 23, 1863, entitled "Spiritualism at the White House." It described the charlatan, Charles E. Shockle who, with "supernatural powers," moved the portrait of Henry Clay, caused the chandelier to sway, pinched the ears of the secretary of war, twitched the beard of the secretary of the navy, and rapped out impor-

tant and significant warnings concerning conduct of the Civil War. These drew derisive laughs from the assembled guests, including the president. But Mrs. Lincoln was deeply impressed.

The mulatto seamstress, Mrs. Keckley, who remained with Mary Lincoln when the rest of the world shunned and forgot her, arranged for the first lady to meet one Colchester, posing as the illegtimate scion of an English peer. A secret seance was held for Mrs. Lincoln in a dark room at the Soldier's Home. There, Colchester "produced" messages from Willie in a script scratched on the wainscoting, tapped on the walls, etc. The following day, Noah Brooks, the correspondent, exposed the hocus-pocus of the charlatan and revealed the true state of affairs to Mrs. Lincoln. Colchester quickly left Washington.

Yet such was Mrs. Lincoln's state of mind, that her husband knew he could not discourage her faith in clairvoyance by flat deprecatory statements. As Sandburg explains these assemblies in the White House: "Joined to whatever of fun, frolic, wit or macabre humor of psychic phenomena Lincoln might have thought he could get from an evening session with a spiritualist, there may have been the mixed motive of publicity with much pleasantry, discrediting it so that Mrs. Lincoln would give less time and worry to the numerous tribe of mediums."

The murder of Abraham Lincoln was the severest psychic trauma that the diseased mind of Mary Todd could possibly have suffered. The war had ended, peace was restored, the nation unified. Sitting with her husband in the decorated box at Ford's theater, the sea of admiring eyes turned upon the president was a symbol of the international esteem and respect that he had patiently earned. How this must have filled Mrs. Lincoln's cup of satisfaction and glory to the brim! And then? The sudden flash of a pistol, brain and blood flowing over her shining, expensive gown, the screams, and chaos!

Her depression following her husband's death was certainly justifiable. There is no argument about that. But its prolongation was pathological. She was to have had four more years in the Executive Mansion. Four more years of power, four more years of playing queen. In a trice, her triumph, her kingdom, her entire world of supremacy, were snatched from her grasp and shattered. She had become the ex-first lady; henceforth she would be referred to as the wife of the former president. No more newspaper notices, no more dinners, no more receptions, no more sprees of wild spending.

She could not bear to leave the White House. That thought was the most galling of all. Beneath the surface, she had always remained a child. Jewelry, rich silks, fine carriages—these were the material things that

spelled happiness for her. She had never, for a single day, been faced with responsibility. There had been either her father or her husband who shouldered the odious task of management. Now, for the first time, she was alone! Worse, she was on her own in the midst of a world that was unsympathetic, cold, and ready to forget her immediately. And she realized she would be forever unwanted, uninvited and shunned. She showed this in a series of letters, heavy with bitterness and burning anger that "such a devastating curse . . . rode in my blood and brain." She was at once frantic, frustrated and furious. She asserted, with theatrical self-pity that she was poverty-stricken, yet documents indicate that Lincoln's estate was more than sufficient for her needs and those of Tad. (Robert was self-supporting.)

Mary C. Ames, writing of the events immediately following Lincoln's death, said, "The shock of his untimely taking-off, might have excused a woman of loftier nature than hers for any accompanying paralysis." The term "paralysis" was used ill-advisedly for there was no actual physical incapacity. She was mentally barred from leaving her beloved arena of power. For five weeks, she was prostrated by grief, weeping almost continuously. She expressed the most depressing thoughts, wailing that she "had nothing further to live for" and "asked God, in His mercy, to take her from her suffering." She remained in her upstairs apartment, alone except for servants.

So indifferent to her plight was the public, that she was left without adequate protection. As a result, Washington hoodlums stormed the White House and removed every item except the four walls and ceiling in each ground floor room. Later, Mrs. Lincoln was accused of having sacked the Executive Mansion of its valuable fittings, an accusation that was debated on the floor of Congress as late as 1875. That crate after crate of personal belongings were removed to Springfield is not amazing, when one pauses to reflect on the myriads of baubles, dresses and fineries she had accumulated in five years as a result of her insatiable thirst for beautiful and expensive possessions.

She became more depressed but did not resort to suicide because "her Tad needed her." She pictured herself as destitute and advertised a public sale of a few personal belongings, a fact that caused Robert no little embarrassment. Her headaches increased in severity and intensity. Self-pity mounted until she felt that she had been "traduced by the entire nation." Reading in papers that she was demented, she traveled to England with Tad where she remained in quiet seclusion which she broke by writing

to the sister of a congressman sojourning in Paris a letter filled with unkind and totally unjustified remarks about Mrs. Grant.

"Burning pain consumed her brain." She returned to Florida with Tad, and in 1871 wired her family physician she would meet him in Chicago because he was the only one "who could save her dying boy." Tad was in perfect health at the time. The examination in Chicago proved that. Mrs. Lincoln mentioned that her trip from Florida had been enjoyable barring one incident in Jacksonville where some enemy had placed poison in her coffee. People were lying in wait to murder her.

She spent a night in the Grand Pacific Hotel, with Robert first sitting up in an adjoining room to watch her, then moving to a couch in her chamber because she said she was in peril. She tried to slip out of the hotel, and, when stopped by her son on the elevator, cried, "You're going to murder me!" Chicago would be consumed by a great fire, with only Robert's house left unscathed; she produced $75,000 worth of negotiable securities she had been carrying around; she said she had been robbed in Florida by the Wandering Jew; then, when returned to her room, she sat down to listen to his voice coming from the wall.

At the age of 18, Tad contracted typhoid and died. The distracted and mentally tortured woman had her third shock by the hand of death. It seemed to be the last straw in an ever increasing stack of precipitating factors to her psychosis. Robert had gone from her side when he had married. She was now stripped of husband, children and friends. She complained of flaming needles piercing her head. A constant vigil must be maintained for persons waiting to slay her. An Indian was pulling wires from her eyes; and there were steel springs in her brain which physicians were removing. In two days, she bought over seven hundred dollars worth of hosiery, gloves and handkerchiefs; hundreds of dollars were spent in the same time on jewelry, perfumes and bolts of silks. Although she had no home of her own and was unwilling to live with Robert, she purchased almost six hundred dollars worth of draperies. She received warnings of death from her husband with appropriate table raps detailing the hour and place.

Hospitalization—Following certification by a competent physician and a jury trial to decide the question of insanity, Mary Todd Lincoln was declared "insane and a fit person to be sent to a state hospital." She was legally committed; Robert was appointed her committee; and, in June of 1875, she was removed to a private sanatorium in Batavia, Illinois. On the day of the hearing she made an attempt at suicide.

She was placed under the care of a Dr. Patterson and seemed to show rapid improvement almost from the first day. She walked, talked and ate with the doctor and his family, and slept in their part of the house. She dismissed the idea that her sorely tried son was her enemy. She became happy, and denied hallucinations, delusions and other aberrant ideas, so that in three months she was permitted to leave, returning to her sister, Elizabeth, for a visit. Within 18 months, her property was restored to her, and she was once more "a free woman."

She told her sister, with a rare show of good judgment, that she "would henceforth be regarded as a lunatic by everyone" and would adjust easier "in the midst of strangers." Hence, she left this country, traveled extensively abroad, and finally settled in Pau, France, in her sixtieth year. Here, a complicating factor resulted. Climbing a ladder to hang a picture, she slipped and fell to the floor. She was kept in bed because of "inflammation of the spinal cord" which left her with a partial paralysis of both lower limbs. However, she was able to get about later, visited Nice, and finally sailed for New York. On arrival, she was about to proceed down the gangplank when she was held back by an officer, who informed her that "an important lady was to disembark first." And for whom did the wife of a president have to yield? For whom were the people on the dock yelling and pushing? For whom were reporters holding pencils poised to catch the first word uttered? An actress! The great Sarah Bernhardt! No one noticed the stooped, trembling old woman with gray hair and wrinkled face.

Back to Springfield came Mary Todd Lincoln, to the house where she had first gone after the marriage to Abraham, her martyred husband. Here she shut herself in from a world that shunned her, remaining alone with her mementos of another day; the baubles, the gew-gaws, silks, satins, programs and announcements of a triumphant era that had been all too brief and now seemed like a wonderful dream out of a dim, misty long ago. Alone, with but a solitary candle that threw eerie shadows over the walls, Mary Todd Lincoln fingered the souvenirs of sovereignty which were piled so high some "feared the floor of the store room would give away."

Her paralysis rose from knee to pelvis and higher and higher so that finally she was forced to remain in bed where she developed one furuncle after another. Her resistance ebbed, and finally on July 16, 1882, in the twilight, Mary Todd Lincoln breathed her last. From her grotesquely swollen finger, a wedding band had been removed. It bore the inscription: "A. L. to Mary, Nov. 4, 1842. Love is Eternal."

Differential Diagnosis—The autopsy report is vague and sketchy. Microscopic studies were lacking. The stains and precise technique of today were not available. Grossly, the brain appeared atrophied with shrunken convolutions and widened sulci. No mention is made of sclerosed vessels, neoplasm or abnormal structural defect. Dr. Thomas W. Dresser who performed the postmortem examination diagnosed the condition as "really a cerebral disease." His professional opinion was to the effect that Mary Lincoln's impulsive outbursts and associated mental symptoms were due to tissue changes that were present from early life, if not "before she was born." Can we correlate these vague facts with modern neuropsychiatric knowledge?

So-called functional disorders can be ruled out in the consideration. Her illness was not a psychoneurosis. There were no compulsions, obsessions, attacks of anxiety, neurasthenic complaints or any of the other well-known symptoms of the neuroses. Her headaches were not the "pressing, dragging weight sensations" of the neurotic. She suffered pain that apparently had organic background. Her personality traits were anything but those of the neurotic.

Manic-depressive psychosis is likewise unacceptable. She never presented a picture of predominating emotional symptomatology with either increased or decreased speech and movement for any appreciable time. Only toward the end, after a half century of mental illness, did she display depression which was not entirely without foundation. Likewise, schizophrenia can be eliminated, since her psychosis was always expressed in external factors without evidence of withdrawal of libido from reality. While she showed transitory hallucinations and delusions shortly before commitment, these occurred after years of apparent mental illness; and her short period of hospitalization, with amazingly rapid recovery, is not compatible with a diagnosis of dementia præcox. That she was seclusive in her terminal years was not entirely subjective. She found welcome and haven nowhere.

Riley, in reviewing all the available postmortem reports on patients diagnosed as migrainous, points out how vague and lacking in uniformity are the findings. But it seems possible and quite probable that Mrs. Lincoln was a victim of migraine. It is equally possible that she suffered from epilepsy—or at least an "epileptic equivalent." She certainly manifested characteristic personality traits, i. e., an overwhelming narcissism combined with ambivalent manifestations. Reference to a convulsive seizure has been quoted. With the etiology of both migraine and epilepsy not yet established, it is often pointed out that these two entities have similar features. Thus, migraine is frequently referred to as "sensory epilepsy."

Did Mary Lincoln's illness meet the "requirements" of migraine? The time of onset is commonly between 15 and 25; Mrs. Lincoln's symptoms—objective and subjective—were first observed in early womanhood. In migraine, intense, stabbing pain occurs at irregular periods with no definite interval, and lasting from hours to days. Our patient followed this pattern. The illness is commoner in urban than in rural communities. Mary Lincoln's symptoms were first noticed in Springfield, Illinois, reaching their zenith in the capital. It is said the "thinking type" of individual is usually the victim of migraine. Certainly Mrs. Lincoln was an intellectual woman, trained, cultured, highly intelligent and capable of shrewd mentation. Further, tense situations, excitement and over-work are given as precipitating factors to attacks. Her ambition and political life brought her that—and increasingly frequent attacks.

Unheralded outbursts of irritability, rage, overactivity, etc., may usher in or accompany a siege of migraine. Mrs. Lincoln's history closely follows this line. Visual disturbances of wide and varying kinds are common. Did she not complain of "hot wires drawn through her eyes" with a "burning flame in her head?" In about a third of the cases, psychic phenomena are recorded, especially where the illness is protracted. Hallucinations, delusions, terror, depression, suicidal intentions and attempts, ideas of reference and persecution—all have been reported. Mary Lincoln manifested all of these in the end.

Her rapid improvement after but three months of hospitalization is significant. In the treatment of migraine, beneficial results have been reported from such simple measures as: regulation of the daily routine, quiet environment, plenty of rest, sedation, bland, easily digestible food, elimination of excitement, etc.

It is felt that her terminal paralysis was the result of her spinal injury suffered at the age of 60. It is quite possible that as the paralysis ascended, the inflammatory lesion did likewise, a point that may have colored the autopsy findings.

In view of the facts that are available to us from lay and professional sources, the diagnosis offered in the case of Mary Todd Lincoln is migraine.

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THE MANAGEMENT OF EPIDEMICS IN STATE INSTITUTIONS

BY SAMUEL R. LEHRMAN, M. D., AND HERMAN S. ALPERT, M. D.

Necessarily close quarters and large populations combine to make an epidemic in a State institution a matter of deep concern. The value of psychiatry is considerably lessened by the presence of somatic pathology; and institution physicians are constantly on the watch to prevent epidemics. Should they occur, every effort is made to control and eradicate them. Specific remedies for some of the contagious diseases simplify the task, depending on the efficacy of the specific and the efficiency of methods of discovery, quarantine and treatment of contacts. Many epidemic diseases, however, cannot be combatted by specific means. In such an event, symptomatic treatment must be employed; and the quarantine of all affected patients and contacts must be most stringently enforced. In addition, attempts should be redoubled to locate and remove the source.

This paper is a report on epidemics representing both types. The epidemic of measles which occurred recently at Letchworth Village* is a good example of an epidemic for which a specific exists in the form of human immune globulin. The management of this epidemic and the results obtained can be compared with the management and results of an epidemic of influenza which was unusually widespread at the Utica State Hospital during the spring of 1940 and which was not subject to specific control.

Epidemic of Measles at Letchworth Village

On May 15, 1939, nine days after admission, F. L. Q., a Negro girl, complained of a sore throat. She was sent to the hospital building, where two days later she developed a typical measles rash. During these two days she came in contact with two patients, R. W. and M. E., who returned to their residence in cottage Y before the measles was discovered. Immediately following the discovery, cottage Y and the hospital were quarantined. The two contacts developed measles on June 2, 1939, having meanwhile already come in contact with all the patients in cottage Y (population 119).†

Human immune globulin, placental extract, was used in the control of the epidemic. Every patient in the cottage regardless of a previous history of measles was injected intramuscularly with 2 cc. This dose is calcu-

*State Institution for Mental Defectives.

†Needless to say, the regulations prescribed by general order 24 were observed in the management of all epidemics described herein.

lated to confer active immunity by allowing the development of a modified form of measles. Since the optimum time for the administration of immune globulin is the first five days after contact, the dose was given as soon as definite contact had been established.

Of the total population of 119 patients, 53 developed measles. Of these, six had a previous history of measles. Of the 66 who did not contract measles, 31 had a previous history. Forty-nine of the 53 patients who developed measles received the immune globulin (92 per cent) within the period of its maximum effectiveness. Table 1 summarizes the number of patients affected with measles and the age distribution of affected cases and those not affected. Inasmuch as the mortality rate of measles is greatest in the age group 1-5 years, it is fortunate that the population of this age group is comparatively small. Yet of the nine patients in this group, five developed measles. It can be credited to immune globulin that the mortality rate in this group, as well as in the other groups, was zero. Some additional interesting observations emerged: (1) The course of the measles appeared to be mitigated. Although the rash and duration were unchanged, there seemed to be a decrease in toxicity and debilitating effects. (2) There were no complications or sequelae directly attributable to measles. (3) The incubation period was apparently lengthened. (4) There was a slight reaction to the injection of immune globulin, characterized by an erythematous area with some tenderness over the site of the injections. About 16 per cent of the children developed a rectal temperature of 100.6° or more, but this subsided within 48 hours.

TABLE 1

Age group	Population all injected	Number of patients contracting measles	Number apparently immune
0- 1 year	0	0	0
2- 5 years	9	5	4
6-10 years	47	25	22
11-15 years	42	17	25
16-20 years	7	3	4
21-25 years	9	3	6
Over 25 years	5	0	5
Total	119	53	66

Epidemic of Grippe-Like Cases at the Utica State Hospital

On February 24, 1940, there began an outbreak of upper respiratory infections which appeared in many cases to be of greater severity than the common cold. This epidemic was rather widespread, but most seriously affected the female continued treatment service known as south side. When the last case was discharged on March 26, 1940, it was revealed that 232 patients (of the south side population of about 875) had been affected.

This epidemic was not without precedent and therefore offers a definite challenge to preventive medicine. It has seemed almost impossible to prevent grippe-like outbreaks which occur every spring. In 1938, a similar outbreak began in January and was not under control until April 15 of that year. Fifty-seven patients on the south side were affected. Four patients with pneumonia were included, two of whom died. In three other deaths, occurring in elderly patients, it was felt that the epidemic played a contributory rather than a primary rôle. However, the total mortality rate was about 9 per cent.

The following year (1939) the outbreak began in March and was controlled by April 15. There were 62 cases on south side and three deaths (one due to pneumonia, two other pneumonias recovered). Here again it was felt that the epidemic disease played only a contributory rôle. The total mortality rate was about 6 per cent.

It was impossible to determine the epidemiology of these epidemics as well as that of the epidemic of 1940 which was much more widespread. It was suggested that the protracted winter (unusually severe during 1939-1940) coupled with overwork made necessary by such a winter, plus the lack of sunshine, all combined with the lower quality of food which prevails in winter, to create a lowered resistance. At an opportune moment during this period of lowered resistance, the disease may have been brought to the hospital by a visitor or an employee, or there may have been more than one focus, and the disease could then spread intramurally.

The exact nature of this epidemic was also difficult to determine. Microscopic examinations of nose and throat smears from all patients revealed nothing unusual. In very few cases pneumococci predominated. But these cases, as can be seen from Table 2, were exceptions. The clinical picture of most of these patients resembled grippe, but all typical signs of influenza were not necessarily present in every case. The symptomatology consisted of malaise, elevation of temperature, running nose and sore throat following an acute onset.

TABLE 2

Year	Total number of patients affected	Total deaths	Number of patients with pneumonia	Deaths from pneumonia	Total mortality rate (per cent)
1938	57	5	4	2	9
1939	62	3	3	1	5
1940	232	2	2	2	Less than 1

The character of these epidemics seemed to be identical for the three years. It should be stated, however, that in 1938 sulfanilamide was not used except where throat smears showed the presence of B hemolytic streptococci. In 1939, sulfanilamide was used in all severe cases; in 1940, in addition to the administration of sulfanilamide in the severe cases, the definite pneumonias (confirmed in each case by X-ray) were also treated with sulfapyridine. (Pneumonia antiserum was not used because of the unusual or undifferential types).

The 1940 epidemic on south side was managed as follows: Two wards were completely given over to the care of the patients affected. Ward 21 was reserved for patients who were fairly comfortable mentally, while disturbed or depressed patients were sent to ward 20. As soon as a new case was discovered, the patient was isolated on one of these wards. All visitors were excluded from the hospital. No affected employees (including physicians) were permitted on the wards until symptom-free. Individual treatment consisted of bed care, high caloric diet q. i. d. with forced fluids and fruit juices. Aspirin and sodium bicarbonate (10 gr. t. i. d.) were given to all patients with an elevation unless these patients were receiving sulfanilamide or sulfapyridine. Patients with sore throats received throat irrigations (warm sodium bicarbonate solution) or painting (with 10 per cent argyrol) and brown mixture or Stokes' expectorant were given as needed.

Among the 232 cases treated in 1940, there were only two deaths; and both of these occurred as a result of pneumonia. Both cases were treated with sulfapyridine. The mortality rate in this epidemic was less than 1 per cent. Statistically it cannot be determined what led to the reduced mortality in this epidemic as compared with those of preceding years, but it is strongly suspected that the freer use of sulfanilamide played a definite part.

SUMMARY

1. A study of the epidemic of measles occurring at Letchworth Village reveals the comparative ease with which a contagious epidemic can be controlled when adequate quarantine measures are coupled with an efficacious specific remedy.

2. In the management of an epidemic of influenza, such as was rampant at the Utica State Hospital in the spring of 1940, quarantine must be strictly enforced and treatment should be symptomatic with the liberal use of sulfanilamide compounds where indicated.

3. Where specific remedies do not exist, the management of an epidemic is more difficult but not necessarily inefficient. As a preventive measure it would appear to be advisable to attempt to better the diet by supplementary fruits, vegetables, etc., in late winter and early spring.

4. Even "mild" epidemics occurring in institutions are of serious import because of complications and sequelae.

Queens Village, N. Y.
Thiells, N. Y.

ADJUSTMENT OF THE EPILEPTIC TO HIS ENVIRONMENT

BY CHRISTIAN E. F. LAATSCH, M. D.

Estimates of the number of epileptics in New York State and the country as a whole vary, but certainly they are numerous enough to constitute a definite and distinctive problem. Most of these unfortunates get along, and are cared for in some manner outside institutions, but a considerable number absolutely require hospital care.

A change in environment always requires more or less readjustment by any person undergoing it, but this is especially true of the epileptic when entering into the required routine of a state institution. Those with an I. Q. of less than .65 or .70 suffer somatically just as much as their mentally better endowed companions in affliction; but they do not have so keen a realization of their desperate and often hopeless prognosis.

As every one occupied with mental and nervous disorders doubtless is aware, epilepsy is not a nosological entity, but a syndrome of symptoms due to varied etiological factors. When the diagnostic trail forsakes the beaten road and leads us along an obscure path to end in a squirrel track up a tree, the patient suffering recurrent convulsions with unconsciousness is said to be an idiopathic epileptic. That is, he has seizures of a kind individual to the particular patient, and for which no one has definitely been able to assign a cause. Please be so indulgent as to permit the quotation of an authoritative definition of epilepsy. Grinker[1] of Chicago says: "An inclusive descriptive statement would incorporate under the term epilepsy, recurrent paroxysms of convulsive movements, sensory psychic dysfunction with or without loss of consciousness. Such a vaguely definable group of conditions, produced by a diversity of possible causes, cannot be termed a disease." Israel S. Wechsler[2] states: "By the term epilepsy is understood a sudden, brief or prolonged loss of consciousness which is usually accompanied by a convulsion. A number of other manifestations frequently precede, accompany, or follow the epileptic attack, but it is essentially characterized by unconsciousness or disturbance of consciousness with more or less amnesia and the convulsive state." Quoting from Lennox and Cobb,[3] "Most authors of the present accept the literal meaning of the word and think of epilepsy as a seizure: i. e., as a symptom rather than as a disease entity. We define it as a syndrome characterized by the sudden appearance of paroxysms, of which convulsive movements or loss of consciousness or both, are a principal element."

As defined in the foregoing statements, epilepsy is a set of symptoms and not a definable disease. When the causative factors of recurrent con-

vulsions accompanied by derangement of consciousness are undeterminable, the usual diagnostic label is "idiopathic epilepsy." It is not now pertinent to discuss heredity, epileptic diathesis, or any of the theoretical causes of this affliction. The common denominator of recurrent derangement of consciousness with varied manifestations of convulsions, is however relevant to our present consideration, for this is the condition to be combatted.

Patients coming together on the admission service of an institution for epilepties, represent the most varied social strata with every conceivable ethical and religious background. They have, however, one thing in common, which is the inability to maintain themselves. Cut off by recurring seizures—even though otherwise fit for remunerative activity—from all hope of gainful employment, they are frequently shunted into Craig Colony under various pretenses. To gain the patient's consent or to overcome his objection to hospitalization at Craig Colony the most unfounded statements and promises are often made. Patients are sometimes told by their relatives and also by those whose training and ethical responsibility should prevent their participation in such deceptions, that a few weeks of rest, or the mountain air, or the country life, or special training facilities will restore them. Patients frequently enter with the fixed idea of leading something like a millionaire country club life, with the inevitable disappointment making their acceptance of the necessary routine difficult or impossible to obtain.

To achieve the cooperation of the patient and also of the family is the first, and a very important, step in treatment. Both patient and family often labor under varied and sometimes bizarre conceptions. These must be set right, if possible, and they frequently are not. In dealing with relatives and others interested in patients, honesty is not only the best but really the only feasible policy—especially when half truths, white lies and downright prevarications have been aimed at the patient and his family. In most cases it is good practice to be perfectly frank with those responsible for the patient. They must be made to realize[4] "That epilepsy is a most intractable disorder, and if a person suffering from it begins to show improvement under two or three years, he or she has every reason to feel encouraged."

With the patient, less frankness is in order, although misrepresentations must be avoided. His morale must be maintained; and, therefore, a patient cannot be informed of his doubtful or hopeless prognosis. About all that is possible, is to refuse to discuss with the patient the probable outcome of his disease. Needless to say, this requires all the tact one has available. Questions which usually should not be answered, or certainly not in a definite manner, are: "How many or what percentage are cured?" "How

long will I have to stay here?" Neither must one be tricked into promising a definite place of residence in the Colony, or a definite occupation or method of treatment. While the average layman has small knowledge and perhaps less faith in medical ethics; if of reasonable intelligence, he can, and usually does, comprehend and accept statements like the following: "We are not able to say what will be the outcome of your relative's disease but you may be assured that we will do everything that is possible to improve his condition. His chances of recovery, whatever they may be, are not impaired but enhanced by his residence here at Craig Colony. It is unfortunately possible that he may become worse under our care; but if so, he in all likelihood would do so much more quickly while at home. We hope that we will be able to give you a favorable report when you make your inquiry, but in any case we will tell you our honest opinion for we have nothing to conceal." The foregoing and similar assertions can be maintained, because founded on facts. If the relatives accept them, well and good; if as too often is unhappily true, they are unreasonable, fault-finding and threatening, a position has been declared which can be sustained.

In any attempts to adapt the epileptic to life in an institution, his personality must be evaluated. Jelliffe and White's summation[5] of the "epileptic constitution" seems particularly apropos. They write: "The classical epileptic is apt to be morose, irritable, suspicious and hypochondriacal He is quite characteristically unreliable and with it all presents a very aggressive form of sentimental shallow religiosity. He is egocentric to a very considerable degree, paying great attention to himself, his own feelings, his state of health, his physical comforts, and his immediate surroundings. In addition to these traits of character these epileptics are usually lazy, frequently they lie openly, present an attitude based on high moral standards of great respect and consideration to one's face and quite the opposite when one's back is turned. While good-natured, even tempered well disposed epileptics exist, they are more apt to be most difficult problems to get along with, and as a class in a hospital are most difficult to care for."

Whether the foregoing constellation of troublesome characteristics is the precursor of epilepsy or a resultant the fact remains that many, if not most epileptics react in just that way, and are accordingly most difficultly adjusted to socially acceptable group behavior. On occasions when interviews with parents and other relatives have been possible, it has been noted that the relatives frequently manifest to an abnormal degree, many of the

traits which make up, what some people choose to designate, as an epileptic personality. These familial aberrations are a handicap to the patient which must be met as best one can.

That a cross-section of society contains a considerable number of epileptics who manage to meet their environmental requirements is a fact. However, various vicissitudes cause many of these persons to succumb to their handicap, and institutionalization then is necessary. Those patients who have completely maintained themselves, or perhaps have even supported a family, are generally much more reasonable and cooperative than those epileptics who have been sheltered and supported by others. Those, who were self-supporting before coming to Craig Colony, usually accept hospital regulations and cooperate. With these patients, socialized by their assumption of economic responsibility, the problem is one of keeping up their courage. Their first concern upon entering a Colony or other institution for epileptics is the same that would occur to any rational person in similar unfortunate circumstances. "What are my chances of being cured?" "How long will it be necessary for me to remain here?" One dare not answer these queries with a blunt statement of prognosis which all too often contains little hope of recovery or even of improvement. Nor must one be inveigled into any statement less or more than the exact truth. All experienced doctors know that in all cases of doubtful outlook the temptation is great, to cheer the patient at least temporarily by telling him those things which are pleasant to hear, but this well intentioned weakness must be resisted when managing a case of epilepsy. It is readily comprehensible that the private practitioner finds this policy of exact truthfulness more difficult to follow than does the institutional physician, but the more nearly it is approximated, the better for all concerned. Were any but the patient's best interest under consideration the policy necessarily pursued could be deemed one of equivocation; for the patient is permitted to draw such conclusions as he will, without being able to attribute any misrepresentation or deception to the doctor in charge. The relatives, however, should have made plain to them what the patient's future probably will be; the patient must be spared, and yet not deceived by specious promises.

The routine of admission is like that of any well regulated hospital; it should be as prompt and thorough as possible, prompt so as to forestall the patient's ideas of neglect, and both physically and mentally comprehensive, to reveal liabilities and assets, so that management of the particular case may be effective. After the preliminary observations are com-

pleted the process of adjustment to institutional life begins. To those patients having intelligence of a grade to make it practicable, it is explained that they must themselves make the first step towards treatment of their malady, that of accepting the necessary hospital regulations designed for their own advantage and protection. The necessity of harmonious associations with fellow patients and cooperation with officers and employees is stressed, and the idea is presented that the patient's happiness or unhappiness depends mostly upon himself. It is explained that treatment for epilepsy is much more likely to benefit the calm and contented person than one who is constantly resentful, quarrelsome, and faultfinding. The further statements are made that the nurses and doctors, like those of other vocations, can experience satisfaction only if a job is successfully completed, that is, the improvement or recovery of the patient. Whatever the future reaction of the patient and his relatives may be, this statement, since strictly based on facts, cannot be controverted.

Experience with those epilepties admitted to our institution has repeatedly demonstrated that while an epileptic may or may not be of average adult mentality he is most apt to be emotionally immature. It is this fact of emotional maturity or immaturity which must decree what methods are applicable in the adjustment of the newly admitted epileptic. In his home, the epileptic all too often tyrannizes his environment by stressing his afflictions, by tantrums and by varied and often vicious anti-social behavior. In an institution the attempt must be made to inculcate the realization that this is unprofitable to him and retards his recovery if it does not aggravate his disease. Essentially the patient is told: "Behave yourself and you will be happier and have better health than if you misbehave. If you do not see fit to cooperate, all employees and officers will still do all they can for you, but you cannot upset anyone or make anyone unhappy by quarreling or faultfinding. Your bad conduct will react almost entirely upon yourself."

Like countless others, the epileptic seeks to enhance his ego and combat his own, perhaps subconscious feeling of unimportance, by attacking the poise and serenity of others. The fascinating theory that epilepties' reactions are primarily due to an inability to meet the biological and social problems of the individual may not be relevant at this moment, but the fact of their occurrence cannot be ignored. Hence the attempt to make the patient understand that his abnormal behavior (considered apart from his seizures) constitutes only a professional problem, and that he cannot add to the relative height of his own stature by abusing others and causing trouble.

Patients are admitted to Craig Colony as competent, or incompetent, which at first thought, might justify the conclusion that there is a definite line of cleavage between the two classifications, but in actuality this is true only in part. The correctly designated incompetent is at most or all of the time unable to meet the demands of his environment. The competent patient can at the very best meet the demands made upon him only part of the time. It is true enough that the so-called competent epileptic may pass all psychometric tests with average or even superior ratings; yet for varying periods before, during, and after attacks, the patient is in a state of aberration as abundantly made clear by auras, unconsciousness, amnesias, automatisms, furors and fugues. These recurring periods of emotional and intellectual abnormality must ever be remembered and given due weight, by the epileptic's medical attendant.

A consideration of an epileptic's bondage to his seizures may make more understandable his reaction to his life situation. Let us imagine, in so far as we can, what it must be like to be ever under the doom of being suddenly stricken down; or falling anywhere and everywhere, down stairways, crossing streets, in social assemblies; to present a spectacle horrifying to the sympathetic while provoking a sadistic interest in the morbid and pathologically curious. This pictures in some degree the burden of humiliation, frustration and despair that these unfortunates must carry. Economically unable to compete; for church, state or profession unfitted; in social and domestic circles a burden or even a menace; is it astonishing that epileptics finding themselves social misfits and pariahs, should react abnormally?

Whether the patient's conduct is, in varying degree aggressively antisocial, as frequently it is, or whether he is tractable and cooperative; the clue to his behavior is found in his sense of inadequacy and frustration. To quote Noyes:[6] "When tempted to conclude that the syndromes we designate as epilepsy involve anatomical, physiological and physiochemical processes solely, we should remember that the balance of functions may be disturbed by mental impressions and that organic disorders may be produced by mental disorders. More and more however, are psychiatrists beginning to look upon that convulsive symptoms complex known as essential epilepsy, not merely as a physical and chemical problem, even though processes at the physicochemical level may be involved, but as the psychobiological life reaction of an inadequately equipped individual to psychic stresses within; and to psycho-social strains or environmental realities without."

Lennox's recent statement in his paper on drug therapy of epilepsy, is equally pertinent in the psychotherapeutic management of a case. Lennox[7]

writes, "In his conduct of a case the physician will with humility recognize the odds against him, but will work with and not against the healing physiologic mechanisms and will remember that very small therapeutic weights may tip a heavy scale in a favorable direction."

As in all other aspects of psychotherapy, only a limited number of epileptics offer any considerable possibility of being aided by this approach. Those of fair intelligence with relatively infrequent attacks—but who because of their affliction have lost one job after another until nothing remains for them but the haven of an institution—may sometimes be helped to orient themselves so that they may carry on a self-sustaining and fairly satisfactory existence.

Those patients who are of lower intellectual levels usually are not responsive to psychotherapeutic measures, with the possible exception of the application of a kindly and just but firm discipline, and such habit training as might be found suitable for other persons of a similar degree of mental defect.

In the case of epileptics who are of fair intelligence and reasonably disposed, but discouraged and beaten, it is sometimes possible to help them by placing their liabilities in true perspective and stressing their assets. It is well to point out that many persons suffer physical and mental handicaps and that frequently the epileptic can manage as well as individuals with weak lungs, cardiac disorders, deafness and other afflictions.

The goal and ideal of all epileptologists is to stop epilepsy; but a physician must be a realist and not overlook any possible psychotherapeutic method in a preoccupation with the always essential search for fundamental somatic causes of epilepsy.

From time to time epileptic patients, usually referred by private physicians, present themselves at Craig Colony for an interview and examination. One of these cases will be cited as an example of the need for psychotherapeutic management. It is the case of a well trained engineer.

The young man under discussion presented himself at the male admission service of Craig Colony and demanded that he be immediately admitted, as he had lost three positions with engineering firms because of seizures and had resigned his fourth job rather than continue to suffer the burdensome thought of losing it by having an attack in public. In an extended interview, the patient's assets and liabilities were noted and balanced against each other. He had experienced an average of four to eight seizures a year. These began in adolescence and continued throughout five and one-half years of university work. The patient did everything in his power to keep the secret of his malady. On one occasion he said he

felt ill and went to a washroom, there had a seizure and so was able to conceal his attack. He brooded over the situation and in a short time resigned his fourth position and thereupon came to Craig Colony.

In discussing his interest and activities at college it appeared that he had been editor of his college paper and had found satisfaction in this activity. It was suggested to this young man that he at least temporarily drop all thought of engineering and that he then go to some small town and secure a job as a reporter on a small town paper. About two months after this interview a letter was received from this young man stating that he had a reporting job on a county seat newspaper in a middle western state. He said he regretted engineering but that he felt that he could hold his reporting job as long as he wished, which relieved him of the anxiety which was ever present while engaged in his professional work. He further wrote that he had followed the suggestion never to indulge in alcohol in any form, but that he always carried a small flask of whiskey so that in case he should have a seizure that he could spill a little of the liquor and so pass off his unusual actions as due to the influence of alcohol. Two more postal card messages were received from this young man, the last a year and a half after the interview, in which he stated that he was "still in the newspaper game and getting along swell."

The just related case history is not given as being a common experience in institutional practice but rather as a suggestion that each epileptic, whether in or out of an institution, may have possibilities of being fitted into a different sphere or guided to a more satisfactory existence, on a lower plane than the one on which the patient failed to meet the requirements.

At Craig Colony we use every available means to socialize the patient and make him assume responsibility for himself in so far as he is able. To this end, full use is made of supervised employment, occupational and physical therapy, an institutional school for younger patients, boy and girl scout activities, glee clubs, patient theatricals, ball games, attendance at movies, church and other activities. As nearly as possible, life for our patients at Craig Colony is made to represent existence in any other community in which good behavior and contribution to the general good, enhance the well being and satisfaction of the individual.

If we succeed, and occasionally we do, in securing the patient's acceptance of necessary hospital regulations and his cooperation with those who strive to aid him, the first step in treatment has been completed; and methods directed towards the elimination or at least diminution and control

of seizures are more likely to be successful. Whatever the prognosis may be it is a first therapeutic duty to attempt the education and direction of the epileptic's personality.

Success, while all too rare, and while frequently intangible, does occur; and that is enough to keep any true physician interested and encouraged.

Summary

1. Epileptic attacks incapacitate the patient for self support.

2. He must be maintained either by relatives or in an institution.

3. Patients are frequently overprotected while at home.

4. They frequently are a major family problem.

5. Relatives, public officials and others often misinform epileptic patients in order to obtain their acquiescence to hospitalization.

6. The epileptic is often an "inadequately equipped individual to psychic stress within, and to psychosocial strains or environmental realities without."

7. The environmental change from home to hospital presents a problem of adjustment.

8. The patient's prospects should be frankly and fully explained to relatives or guardians.

9. The patient must not be deceived, but discouraging details of prognosis must not be discussed with him.

10. Securing the patient's cooperation is the first step in treatment.

11. The patient must be helped to adjust on his particular plane of ability.

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THE MENTAL STATE AT THE TIME OF SUICIDE

BY G. M. DAVIDSON, M. D.

They know a thing which is called sin, and the garden of sin, and have imagined beasts which leer among the branches in the garden, ugly beyond conception. There are three of these and they are called "Shame," "Guilt," and "Mocking Laughter."

—THOMAS MANN, Joseph in Egypt.

This report relating to the mental state at the time of suicide, i. e., the mental content and manifestations of affectivity involved in the suicidal act, represents part of an investigation on suicide conducted by the writer over a period of several years.

The original investigation was divided into three branches: (1) a consideration of the relation of various aspects of the total personality to suicide;[1] (2) a comparative study of the suicidal act as occurring in various settings, such as the generative phases of womanhood[2] and other epochs of life;[3] and (3) a study of the suicidal group compared with a group of individuals who, while showing approximately the same characteristics (including suicidal ideas in some cases) have made no actual suicidal attempts.

The total group studied comprised 80 female and 40 male suicides, with an equal number of patients constituting a control group. With few exceptions, these were all State hospital patients. Their ages ranged from 18 to 76. They represented various nationalities and diverse psychiatric disorders. It was hoped that the investigation would result in revealing traits common to all cases, which in turn would suggest some common underlynig factors instrumental in suicide. Only the mental state at the time of suicide will be discussed here. As the mental state represents a projected summit of the total personality, it reflects the principal etiological factors.

Mental Content

Attention is called to the chief trend. It must be born in mind that it is not the trend as a whole but its affective component which impels the individual. For instance, if we take an involutional case in which anxiety turned to apathy, the trend expressed seems detached; the patient does not react to the ideas he entertains. The same is true for cases of schizophrenia when dissociation of affectivity has reached an advanced stage.

The trend varies greatly. For purposes of study, we may differentiate one type which develops essentially on the unconscious level, from another which develops on the conscious level. To the former, belong trends manifesting themselves symbolically. As in sham-death (which is a recourse to a biological weapon of defense to meet danger); the stuporous immobility of

the death-wish (suicide in fantasy, the patient seeing a vision of himself in heaven); or actual suicides, serving as symbols. Other symbols may be union with a dead love-object, or sexual death as a symbol for "involutional castration." Symbolization of suicide as the expression of a perfect sexual act seems to be a rather theoretical unsubstantiated supposition. To some, suicide symbolizes freedom. Among other trends, we have identifications with others, projections of difficulties, of which guilt is conspicuous, incestuous desires, homosexuality and sexual fantasies of forbidden nature.

On the conscious level, the outstanding trends are guilt, unworthiness, insecurity following the loss of a love-object or of some other cherished thing (of value physically, psychially, ethically), "fulfillment of one's destiny," disillusionment, and those trends referring to sacrificial, ritualistic and pact suicides. There is also the psychopathic variety, as a gesture to obtain one's ends (similar to the situation described by Kaldewey[4] with regard to swallowing of objects). The conscious and unconscious elements, of course, often coexist and intermingle. These trends may be as varied, complex and numerous as are human desires. It would therefore be a mistake in looking for causes of suicide to identify psychopathology exclusively with etiology. In fact, the present investigation has shown that the trends are nonspecific and occur in a large number of nonsuicidal cases.

Affectivity

The popular tendency is to associate suicide with depression. However, it was already noted by Brend[5] that as far as mental cases are concerned, suicide occurs in a variety of mental disorders (not only in the course of manic-depressive psychosis). The same observation was made by Jamieson.[6] Chrichton-Miller[7] observed that the psychoneurotic is free from suicidal tendencies. The writer is inclined to agree with him for both practical and theoretical reasons. For example the *belle indifférence* affect of the hysterical, like other compensatory psychoneurotic manifestations, is preventive of suicide. Again, the frequent recourse to sham-death is significant. Regarding anxiety, which was discussed in connection with involution,[3] the writer accepts the explanation of Janet,[8] that anxiety is essentially preventive of suicide because it represents fear of action. Furthermore, the true variety of depression is accompanied by retardation, which also tends to prevent suicide. On the other hand, the depressed psychopath will only make gestures of suicide.

Close questioning and observation have convinced the writer that the depression displayed is more apparent than real. In certain cases, even when pronounced, this is in reality a disguise for a more primitive affect, of great intensity and obviously thalamic in character. With few excep-

tions—rare suicides characterized by the joyous calmness of "fulfillment of one's destiny," those involving rituals such as harakiri, certain cases of involutional melancholia (where there is a longing for death)—the true affect is one of shame, hate and fear. When an apparent depression follows an unfortunate love affair, it is most often not the frustrated love but shame, pride, fear of ridicule, hate and revenge which incite suicide. This is seen in Malinowski's[9] savage, who, while jumping off a palm tree with suicidal intent calls out the name of his adversary; the same motive impels Tolstoy's Anna Karenina, who, when committing suicide, has in mind revenge on her lover.

The above has been observed but not properly understood because of failure to evaluate affectivity, the situation being attributed to various causes. Experience shows that when patients speak of sickness, disillusionment, worry over lost values, and so forth, as causes for suicide, the affectivity is in reality connected with such things as acute insecurity arising from fear of the unknown future, dread of facing a situation, injured pride, shame of consequences. Rattray[10] tells us that the Ashanti of the Gold Coast, who generally prohibit suicide, allow it in order to escape ridicule by others, or to follow the beloved. Confucius recommended suicide for similar reasons. St. Domnina, who was sanctified because of suicide together with her two daughters in order to escape violation, is another example. The Biblical suicides were committed to punish enemies (Samson), to avoid falling into captivity (Saul), because of injured pride (Abimelach, Ahithophel). Eleazar ben Jair, after the fall of the fortress of Mossada in 73 A. D., influenced 960 persons to commit suicide to avoid shame and humiliation. This does not seem unlike the contemporary mass suicides reported to have taken place in certain European countries. The powerful influence of shame is seen in the account by Hoffman[11] of an epidemic of suicides among young women in a Scottish town in the sixteenth century. A resourceful mayor proclaimed that the nude bodies of the suicides would be exposed on the market place. There were no more suicides.

Discussion

Before discussing the workings of the mental state in suicide, certain theories on suicide should be mentioned. It is traditional for the medical man to consider pathological data first. In this regard, the writer wishes to refer to the work of Pfeiffer,[12] who concluded that suicide is an abnormal reaction conditioned by transitory or permanent physiological or pathological states. Examination of Pfeiffer's material, supplemented by postmortem investigation in certain of the writer's cases, does not tend to sup-

port his theory. Postmortem findings are definitely nonspecific. On the other hand, certain conditions may be regarded as the result of psychic influences.

As for "mental" theories, the psychoanalytic attitude merits careful consideration. According to Freud,[13] sadism is the fundamental instrument in suicide. Unconscious sadism is originally directed toward an object. When libido is withdrawn from the object, the energy is directed toward the ego, and the individual kills himself. Freud[14] further introduced the concept of the death-instinct which, according to him, works in opposition to the life-instinct and signifies an innate tendency of the organism to seek reinstatement of an earlier condition. It must be stated, however, that Freud, as well as certain of his followers, considers the situation speculative. Others elaborate on it to a great extent.

Abraham[15] observed that suicide is based upon a special identification mechanism. The individual identifies himself with another person whom he first loved and later hated. He now hates himself, therefore kills himself.

Schmideberg[16] states that it is not the death-instinct which drives the person to suicide, but anxiety interfering with the life-instinct. This author thinks that suicide prevents one from committing a forbidden act, or that it is an act which may result from fear of death or fear of life. Again, when a person commits suicide he may hope for a better life (the latter may be traced to the racial memory of man, as seen from studies on primitive societies).

Somewhat in contrast to these individual approaches, the sociologist interprets suicide in terms of variations of social forms (Durkheim[17]). The authropologist believes that suicide is tied up with the general cultural patterns of life, and, therefore, varies with reference to cosmoethnosociological factors (Steinmetz[18]). The general psychiatric opinion is well expressed by Gaupp[19] who asserts that suicide has a biological, a psychological, and a sociological aspect. The cause of suicide, according to him, lies in the sphere of the unconscious.

In a former publication,[1] the writer emphasized the multiplicity of factors. An analysis of a number of factors pertaining to suicide—such as heredity, physique and physical conditions, age, sex, meteorological data, race, religion, mental states and modes of suicide—convinced him of their nonspecificity, even though they might influence the situation. This in turn indicates the nonspecificity of any single theory on suicide.

With the above in mind, the writer wishes to discuss further the psychoanalytic approach.

First, the alleged death-instinct. It is justifiable to doubt the existence of such a phenomenon for more than one reason. The definition of this supposed instinct, according to Freud[14] an innate tendency toward reinstatement of an earlier condition (which sounds like a paraphrase of the Biblical "for dust thou art and unto dust thou shalt return"), is hardly satisfactory. Furthermore, the supposition of the existence of a death-instinct as a necessary running mate to the life-instinct is also inadequate. There is no actual biological or clinical evidence to support the theory. Repeated suicidal attempts by the same person may be due not to an "impulse to die," but to the "mnemic urge of repetition."

The usage of the term "instinct" appears similar to the physicist's usage of the term "ether." In this connection, Sir James Jeans[20] observes that each extraneous theory introduced to explain a phenomenon would introduce an "ether," this "ether" possessing whatever properties would be required. This would result eventually in as many "ethers" as unsolved problems; it would be well to follow the physicist who gave up all ethers but one. There seems to be a tendency to overstate the symbolic significance of an instinct. If the term is to be used at all, it is sufficient to regard it as representing a single propelling force which may have several constituents.

The writer holds that a desire to die could be normal only in that state of "physiological death" considered by Metchnikoff.[21] Death wishes in most cases are thus abnormal. It would seem, on the basis of present biological evidence and clinical experience, that the wish to die is essentially a desire and hope for a better life, the background of which is the racial memory of man.

The same racial memory of the mystery of death is responsible for the fear of death which may underly certain death wishes. In fact, death as a natural phenomenon must be pleasant. Another basis of death wishes, the fear of life, is due to inadequacy of the psychological integration of the individual, making him unfit for the struggle of life. In such cases, there may also be admixture of the desire for a better life.

Secondly, concerning sadism and identification as "the" mechanism of suicide, these cases have demonstrated an interesting objective point, namely the loss of a "goal" preceding suicide. In a broad sense, this loss may be identified with the withdrawal of libido from an object. The rest of the formula is, however, not demonstrable, although there are cases, especially of involutional melancholia, which suggest the mechanism in question. The theory cannot be accepted as universal because it cannot be applied to all varieties of suicide, harakiri for instance. As Bauerlein[22] described it, the individual is trained in the spirit of harakiri virtually from infancy, thus

creating an uncompromising affective state—to meet certain critical situations—which is entirely independent of any sadistic mechanism. In fact, it apparently evolves from the idea of sacrifice. Again, the "dying together" cannot be explained by sadism. It would seem that we deal in the latter cases with a mechanism akin to *folie à deux*, in which one person is the aggressor, the other or others the recipient (s).

Prehaps a further step in understanding the motivation of suicide may be made in considering a certain physiobiological phenomenon which is described as a "dominant." Spemann[23] has shown that in amphibian development there is a central zone constituted by the dorsal lip of the blastopore in gastrula stage which assumes the lead, controlling the fate of the rest. Coghill[24] based, upon his studies on the salamander, the conclusion that normal behavior depends upon the sovereignty of the total pattern of activity over all partial patterns of activity.

Of special interest for clinical application are the physiological data offered by Ukhtomsky, quoted by Bechterev.[25] This author states that various centers of the nervous system may at times not act in the usual manner. He shows that, in presence of an excitation which he calls "dominant," some mechanisms may be shut off. For example, by stimulation of a certain region of the cerebral cortex of an animal, a perfectly defined local reaction may be produced, such as twitching of a leg muscle. However, if the animal is about to perform the act of defecation, the same stimulus applied to the cortex, at the same point, will no longer produce the twitching of the muscle. It appears that the pathway is blocked because cerebrospinal centers are aroused and are dominating at the particular moment. As soon as defecation has taken place, the blocking is released. Experimental evidence shows that any impulse may become a "dominant." Everyday experience teaches us that the same conclusions can be applied to man. It is possible, therefore, that various impulses, as well as motives similar to those studied may become "dominant." The motive will represent, in a direct or indirect form, the individual's conscious and unconscious difficulties. An impulse once aroused will seek discharge; if not discharged, any additional experience (as shown by experiment) will only accentuate the symptoms and speed up the overflow of the neuroendocrine, the psychic or their combined activity in the associational and motor fields. Fatigue, with the resultant diminution in the acuity of the sensory apparatus, will facilitate inattention and help the development of a dominant. Alcohol and physical disease, in causing accumulation of affect around the "self," will likewise serve to facilitate an impulse in becoming dominant. The foregoing is believed to be the most important feature in the rôle of these conditions in the mechanism of suicide.

The overflow of a dominant into the motor sphere is apparently due to contraction of the horizon of consciousness, which is in turn an accompaniment of the dominant excitation. Concomitant with the contraction of consciousness is a dulling of the senses, hence decrease of the ability to receive impressions from the outer or inner environment. The flow of creation and subordination of impulses (the will) will cease, and with it the normal automatic rejection of that which is unhealthy, so that what results is a state of complete inattention to life. An extreme contraction of consciousness or inattention to life is seen when suicide occurs in obedience to the attempted command of "voices," a state of fusion of thought and action. The development of this fusion which facilitates suicide is well accounted for by the patient himself. For instance, a patient who decided to end suffering by suicide related that she went up to the roof in order to jump. However, when she came to the edge of the roof, she would automatically step back with a simultaneous idea that such death would cause worse suffering. She then tried gas, by turning the jets on and off, under similar ideation and action. Another patient, who thought he was doing the world and himself no good, was on the point of committing suicide when another idea flashed through his mind to the effect that perhaps he could get hold of himself; so he decided to live. Still another patient, who felt that life had nothing in store for her, first decided to kill herself, then thought at the critical moment that there might be something in life for her after all. This situation recurred until counter-ideas became weaker and weaker; finally no counter-idea came forward; i. e., she was positive, so she drank iodine.

The situation is masterfully pictured by Mao Tun, quoted by Edgar Snow, in a story on suicide.[26] A young woman, to escape shame, hanged herself by tying a noose around her neck with her sash: . . . precisely at that moment a vague thought fought for light somewhere in the darkness of her benumbed brain . . . (there is still a way out) . . . but the sash had gripped into her throat and the idea was choked into silence. . . ." Given an opportunity, the situation may change, as in the case of a man who jumped off a bridge by command of "voices." At the time he leaped no counter-idea had appeared, but the time elapsed in falling and hitting the water allowed the counter-idea to come forward; a "voice" scolded him for the act; and he swam ashore.

Such possible manifestations of thought are comprehensible, if we consider that the evolution of thought is concomitant with the evolution of affectivity. In the well organized total personality, thought is independent of action, it may act as a substitute for action, or action may follow thought after an interval. On the other hand, we observe in children of a certain

age the inseparability of thought and action; this is particularly well expressed in speech, which is a motor accompaniment of thought. The same phenomenon is seen in the immature who are unable to think abstractly; and the result here is impulsiveness. This is also observed in dissolution of the personality, as in certain psychotics. If this interpretation of the relationship between thought and action is correct, it may be applied to various forms of self-destruction.

Before decisive conclusions can be reached on the mechanism or mechanisms of suicide, further exhaustive study is necessary. As the problem stands now, it is possible to say only that, since the trend is universal but only a few actually attempt suicide, a special psychoneural constellation must exist to facilitate the act. While the nature of this constellation is unknown, it is evident that the entire personality participates in its creation. At the time of suicide, a blurring of the sensory apparatus occurs, with a fusion of thought and action. In general terms, the situation might be due to a process akin to the "pathological inertness of the excitatory process" in the sense of Pavlov,[27] with consideration of the data of Burridge[28] relative to activity of the central neurons.

According to Burridge, neurons are rhythmical tissues which have their rates and amplitudes. A peculiarity of such tissues is the ability, under certain circumstances, of groups of neurons to unite and beat synchronously in rate and rhythm. The excitation process arises from the interaction of two sources of energy present in each neuron, colloidal aggregation and electrolytes. The synergic action of these two factors mediates the energy of thought or ideas. The basis for the ideas or for the sensations is furnished by colloidal aggregation; the judging capacity is mediated by electrolytes. Because of the limit of intensity and energy power, the more there is of one factor, the less there will be of the other.

It may be assumed that a catastrophic maladjustment of both sources of energy is present at the time of suicide. (This may be due to various experiences, among others the influence of psychic states upon the vegetative nervous system.) It may be manifested in a high increase of colloidal aggregation and an abnormal decrease of electrolytes; this together with hysteretic augmentation of rhythmical activity and slowing of rate, will arouse sensations or ideas to an irrestable height (dominant), diminish judgment to almost nil and reverse activity to thalamic intensity with overflow into action (suicide).

Considering the data of Burridge to the effect that thought is mediated by an alloy of two components, there will be various degrees of expression of thought, depending upon the compositions of the alloys. Comparing

the situation with vision, it may be said that the state of fusion of thought and action (the final step in suicide) is akin to vision, when a glaring, hypnotizing light will cause the cyclist to steer between the lights of an advancing car.

Treatment

Hospital therapy may be briefly outlined: In acute excitement, agitation or anxiety, continuous baths are helpful. Of further assistance are sedatives, the prescription consisting of drugs influencing both the cortical and subcortical levels (e. g. luminal and paraldehyde, or chloral hydrate and bromides). In mild depression, benzedrine sulfate may be of help. In anxiety states due to "dammed-up" libido, choline preparations such as hypotan are recommended. In certain female cases, estrogenic therapy is of advantage. In this respect, besides tests, clinical acumen is the guide for treatment at the present state of knowledge; among other complaints, insufficiency states are benefited by such treatment. (The treatment of involutional cases was discussed in a former study on the subject.[3]) Additional physical conditions should be attended accordingly. Hygienic measures do not require special comment. Occupational therapy in conjunction with or subsequent to the treatments cited is of advantage.

While cases may recover spontaneously, treatment nevertheless helps. Moreover, psychotherapy is indispensable. Frank discussions, encouragement and suggestion are helpful. In view of the limited amount of time available for an individual case, the psychiatrist must assume an active rather than a passive rôle. A great handicap in adequate psychotherapy is the fact that often, no matter how much insight the patient may gain, his desire to leave the hospital at the first apportunity is great.

Since suicide may occur in the course of almost any mental disorder (depression not a criterion), thorough investigation into the total personality is essential. Particular attention must be paid to prevent the patient from developing a state of mind favorable to the rising of a "dominant," in the sense discussed. No matter how trivial an idea entertained by a patient may sound, if this is repeatedly expressed with an accompanying affect of fear, hate, shame or revenge, attempts must be made to divorce the patient from the situation.

In reference to the parole of suicidal patients, the writer considers the patient safe when he or she is able to form an adequate plan for the future. The followup of these cases showed that they made rather good adjust-

ments outside. It is suggestive that, in certain cases, the suicidal attempt causes a discharge of difficulties. This helps the redistribution of the patient's energy and, consequently tends to improve the total personality equilibrium for the immediate future.

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SOMATIC FACTORS IN MENTAL AND NERVE CONDITIONS*

Illustrative Cases

BY WILLIAM SEAMAN BAINBRIDGE, A. M., Sc.D., M. D., C. M.

My special interest in the subject which we are considering today dates back many years. After my graduation from medical college and three years internship, Dr. M. Allen Starr, professor of mental and nervous diseases at the College of Physicians and Surgeons, New York, sent me abroad with a patient. The man was a prominent leader in religious and financial circles, suffering with what was diagnosed as religious melancholia. He had shown at times homicidal tendencies and was determined to commit suicide. He could not be left alone a moment. One night at sea he made every effort to jump overboard; and I found him planning my destruction in order to accomplish his end. His belief that he had committed the unpardonable sin was ever spurring him on.

A constant study of this man for many months was most revealing. Here was a temperate man of 58 years with no history of mental disorder in the family, no luetic background, who had lived a most exemplary and normal life. Why this mental breakdown? I became convinced that he was suffering from a very marked auto-intoxication and treated him accordingly. After two months I left the patient with relatives at a hydro in England. He seemed quite normal mentally and much better in every way. I had not been back in New York more than a month before a cable advised me of another mental breakdown. Returning to England by the next steamer, I found that the patient had had a complete relapse, that his tongue was badly coated, his breath and stools fetid; his suicidal tendencies had returned.

After prolonged treatment for auto-intoxication, the mental state of this patient completely cleared up; he lived 12 years longer, during which time he did some of his best and most lasting work. The abdominal toxemia was the essential cause and when gradually relieved, the mind resumed its normal function. There was no recurrence of the mental disturbance, and the man died of myocarditis and pneumonia.

Dr. Starr, who was one of the leading neurologists and psychiatrists of his day, confided to us prosectors that it took an enormous amount of time to encompass what was known in the field of neurology, but that all that was known of mental diseases was pure speculation and could be covered in five lectures. At one of his last addresses at the New York Academy of

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Medicine, he summed up his opinion of psychoanalysis in one sentence: One ounce of Muldoon is worth more than a ton of Freud! Psychiatry was the then "weak sister" of medicine, the undernourished incubator child. There is no question, however, but that she is developing and giving great promise.

There are over a half million mental patients under care in our public and private hospitals at the present time. In the hospitals in the United States, more beds are occupied by patients with mental and nervous diseases than by those with all other conditions put together. We are face to face with a problem of the greatest magnitude. The constantly increasing complexities of our very life make it more and more difficult for the individual to adjust himself to his everchanging environment. A number of years ago the late Dr. Marcus Heyman, an outstanding specialist on mental diseases, when superintendent of the Manhattan State Hospital, remarked that if mental disease in the United States continued to increase, the patients would have to take care of one another! "Show me the man or woman," he said at one time, "who says he is perfectly sane, and I will show you a mental case." Of course, this is hyperbolic; but we can see that psychiatry is progressing from the field of the speculative into that of the practical.

We approach this whole subject of psychiatry with an aspect very different from that of 25 or 30 years ago. There have been several landmarks of progress. Perhaps one of the main ones is that we now recognize the enormousness of the problem, with its far reaching influence and complexities calling for solution. Another is that with the growth of our knowledge, we are taking a far more rational attitude toward the deranged. This change has resulted from the labor of tireless leaders, too numerous to enumerate; but outstanding among them is Clifford W. Beers, founder of the mental hygiene movement of 30 years ago. It was he who opened the eyes of many to the cruel treatment of the mentally ill and the need for a more humane and scientific technique. Our very paucity of knowledge of this vast subject is a further incentive for us to continue with experimentation and research. We have already done a great deal through the differentiation of mental conditions into types; and through the classification of cases, which is always a help in the fight for prevention and cure.

Although under different names, there are two schools of thought today as there were in the early days of medicine. We now speak of psychogenic diseases (the old Animist school which convicted the "inner spirit" or soul as the cause of disease) and organic diseases (the former Fluidists who believed that the humors of the body were the seat of the trouble). Science should not rely on speculation but should seek for definite causes of certain

mental pathology. There had been such widespread enthusiasm over psychoanalysis that organic factors have been relegated to the background; it is important that this be corrected.

My many years' experience as surgical director of the Manhattan State Hospital and my connections with several other State institutions, have forced upon me the realization that pathologic somatic conditions have their definite etiological relationships in many instances, to the psychic and nervous organism. It is essential that emphasis be placed upon this fact. Too many cases have proved my argument, for the results obtained to be merely coincidental. I cannot go so far as do some psychiatrists who believe that all mental disorders are due to bacterial toxins which cause brain changes, nor, on the other hand, can I agree with others who state that in a definitely mental case there is never a physical cause.

We have, as we all know, what we consider today to be purely functional mental conditions without any somatic basis yet discoverable. The psychiatrist must grapple with these cases on the functional hypothesis until research may establish possibly a better concept. But there are other cases where organic lesions are the definite cause of the mental state, or the means of aggravating a mental or nerve condition which would otherwise be amenable to treatment. It is this class of patient for whom the diagnostician and surgeon are responsible, and not exclusively the neurologist and psychiatrist. My experience has definitely shown that an erroneous diagnosis may be the means of causing a patient who has a reflex psychic phenomenon due to definite pathology elsewhere in the body, to be relegated to a mental institution for life. A thorough and careful physical examination would have lifted the veil.

Lord Moynihan of Leeds, the great surgical leader of his day, in addressing a large gathering of physicians and surgeons in Great Britain a few years ago, said that the door of hope for many seemingly hopeless cases of mental disease will be opened through the treatment of somatic pathology. It is my own firm conviction that there is such a group, small perhaps, but within the range of cure or amelioration through adequate surgery.

Such distinctly psychic manifestations of abnormality as illusions, delusions, hallucinations, persecution complexes, manic-depressions, can in certain cases be attributable to definite physical pathology. The results of toxic goiter or of other endocrinic dysfunctions are well known and do not directly concern the scope of this paper.

For many years I have emphasized, and it is now generally accepted by the authorities in the field, that cancer is not one disease, and has not a single but a multiplex pathology; and, therefore, there is not one but several causes. That is why one type of case will react so differently from

another, to the same treatment. Does not this same rule hold true for psychotic patients? Different types of cures are now being tried, such as metrazol, insulin, other "shock" methods, artificial heat chambers, and the like. As in the case of the treatment of general paresis with malaria, we are arresting the progressive action of the disease in many instances; but who can say conclusively that we are curing it? Mental maladjustment is being approached from many angles, neurological, psychological, chemical, constitutional, and surgical. In this latter field lies a new element of hope, the possibilities of which should be recognized more generally than they are at the present time.

Surely the neurologist, the psychiatrist, the internist and the surgeon must coordinate their efforts, keeping in mind that each part of the body bears a relationship to every other part, and that all can affect the mental and nervous systems. Conversely, the mental can affect the physical. A wise psychiatrist may be of infinite help in a medical or surgical case, and the surgeon, by proper attention to somatic patholgoy may be the means of bringing a seemingly hopeless mental case back to normalcy. This is at least worthy of fair trial, especially considering the belief, as expressed to me by a number of psychiatrists—superintendents of State hospitals—that there is grave doubt as to whether we are curing any more cases of essential mental disease today than we did 25 years ago.

In order to illustrate the point of this paper, that somatic conditions may cause or aggravate mental disease, I shall briefly present a series of case histories. These can be augmented by many others in my files; but they are sufficient to make clear my reason for emphasizing the importance of the subject.

Case 1. E. P.—Female; 53 years; single. Consulted me March, 1937. There were delusions, hallucinations, mental depression, religious fanaticism, and sex disturbances. The patient realized in a measure her mental state. Friends felt she should be committed. As a last resort she sought aid of a clergyman; and this practical minister, exhibiting a most commendable attitude of cooperation with the medical man, referred her to me with the request that I seek a physical basis for the mental condition; that if there were none she would have to be committed to a State hospital. On physical examination I found the left breast absent (removed 17 years previously); clitoris buried in adhesions; a large pelvic mass extending into abdomen. On operation, March 20, 1937, the clitoris was dehooded; supravaginal hysterectomy was performed for multiple fibroids pressing on both ovaries which were flattened out by pressure of the tumor mass and the wall of the true pelvis; ovaries were suspended after cysts were punctured. In a note at the time, I stated: "Believe the conditions found to be competent, producing cause of mental symptoms from which patient has suffered." At present, the patient is in excellent condition; all mental and sex symptoms have completely disappeared; she is now at work as a housekeeper, and her employer reports her as hardworking, cheerful, and happy.

Case 2. C. J.—Female; 52 years; married; with children. She consulted me September, 1926 complaining of "terrific" pain in the head for a year; a drawing sensation back of the neck; constant headache back of right eye; smothering sensation; periods of mental confusion; melancholia; felt she was "going mad." She had X-ray pictures taken of the skull; and the Roentgenologist reported findings negative "except that the sella turcica seems to be partially filled with a new growth." The family history caused suspicions of lues. The Wassermann test was negative. X-rays of hands showed areas of budding and resorption often so typical in hereditary or attenuated lues. Antisyphilitic treatment was instituted. The headaches, smothering sensation and mental confusion disappeared. The patient was able to resume high position in the Eastern Star. In 1933, she successfully went through an operation for appendicitis. At present, 14 years after I first saw her, she is perfectly well and active.

Case 3. R. S.—Female; 26 years; married; has children. Referred to me in August, 1937, by L. A. Lamoutte, D. D. S. She gave a history of menstrual irregularity; a gain of 32 pounds in weight in two years (she weighed 210 pounds); epileptiform seizures since July, 1936, gaining in frequency, with a diagnosis made of "intracranial neoplasm" after several weeks' observation in a metropolitan hospital, under 21 doctors, with all laboratory tests, including infusion of oxygen into the spine, negative. Her husband and her physician had been told there was nothing to be done and that probably, before long, the patient would go blind. I decided as a start, to treat with hormone medication, sedation and diet. For two months, there were no seizures and the patient lost 32 pounds. However, very severe attacks started again, and in November, 1937, the patient was brought to New York from another city, in an ambulance, unconscious, having had repeated seizures the night before. She was unconscious for a week, with several daily convulsions. A neurologist, called in consultation, diagnosed the case as an "intracranial growth," and believed the patient would die. While still in the hospital, she developed pain in the right lower quadrant and left ovarian region. I operated December 21, 1937, removed fibrocystic left ovary, grown to broad ligament and pelvic colon; removed left tube; broad ligament, which contained very large varicose veins, tied off. Pelvic bands and adhesions, causing mechanical constrictions, relieved. Thickened, kinked appendix, full of fecal pus, removed. Immediately following the operation, all convulsions ceased, mental and nerve condition improved; she was able to sleep without sedative. Hormone injections were resumed. At present, the patient is perfectly normal in every way, extremely happy and active.

Case 4. E. A.—Female; 11 years. Referred to me by Dr. Graeme M. Hammond in June, 1916. She had had chronic constipation since babyhood. In Septmeber, 1915, attacks of petit mal began, as many as 20 a day. Hospitalization with diet, etc., had had no effect. Essential epilepsy was ruled out and the patient was sent to me for examination for any possible abdominal condition. I found tenderness over the head of colon and appendix; colon low; cecum distended and prolapsed into true pelvis. X-ray pictures showed ileal and colonic stasis. The operation was in June, 1916. Marked constricting bands involving distended gall bladder, cecum, ascending and transverse colon and sigmoid were relieved. Following the operation, the nervous condition rapidly improved; the number of seizures of petit mal was reduced to a minimum at long intervals; and then, they occurred only after attacks of constipation, fatigue or excitement. The girl was a member of a basketball team at college; energetic; received highest scholastic ratings, and won M. A. degree. At present, 24 years after the operation, she is in excellent health, with no recurrence of petit mal for many years; and she is dean of women at a southwestern college.

Case 5. G. J.—Male; 43 years; married, with children; an executive officer in the United States Navy who served on a transport during the World War. He seemed mentally and physically strong; apparently nervously well balanced. After a collision at sea, however, he developed a mental condition so alarming that I had to have him relieved of duty and placed in confinement under guard. He had hallucinations, showed mental confusion, and marked depression. Physical examination revealed several abscessed teeth and an infection of sinuses. When the ship reached port, the patient was placed under hospital care; the abscessed teeth were removed and the sinuses treated. After these foci of infection were eliminated, the toxic psychosis slowly disappeared. After several months, he was discharged from hospital entirely cured. He lived for years, with no relapse of mental symptoms.

Case 6. G. J. H.—Female; 30 years; single. Consulted me June, 1915. Had epileptic seizures for eight years, of increasing frequency and severity. Marked psychic symptoms and melancholia. Physical examination revealed congested, retroverted, and retroflexed uterus, pressing on rectum; right ovary prolapsed and very tender. Operation July 1, 1915. All conditions corrected. For about a year thereafter had a few mild seizures at long intervals, but mental symptoms markedly improved. Attacks then completely ceased, nervousness and depresesion disappeared, became perfectly normal, and patient resumed profession of dancing instructor. In reply to a follow-up letter not long ago, mother said patient was in excellent health, physically and mentally, had forgotten about her illness, and the entire cure was attributed to Christian Science!

Case 7. A. W.—Female; 25 years; single. I was consulted in August, 1926, by her mother regarding the patient, who was in an institution for mental cases at the time. The anamnesis showed sexual perversion, and religious fanaticism; and the patient was homicidal and suicidal. At the several State and private institutions in which she was placed, the diagnosis was the same: Dementia præcox, paranoid form; prognosis unfavorable; no organic involvement; case entirely mental. In the summer of 1927 during a period of parole—when I was out of the country—her clitoris was removed. There was no benefit. In September of that year, the paitient was brought to me for a physical examination. I found a markedly retroverted and retroflexed uterus, which was adherent to the rectum. The operation was on November 21, 1927. There were adhesions between the fundus uteri and the rectum, and between the left ovary and broad ligament and wall of pelvis. Adhesions were relieved; and a modified Gilliam suspension operation was performed. The patient made completee recovery. All nerve and mental symptoms gradually disappeared. There was no further sexual perversion. A year after the operation, she was examined by an alienist who pronounced her sane; and property which had been taken from her by the courts, was returned. A few years later she took a partial university course, is now managing her own estate and has had no further mental trouble. Completely cured.

Case 8. H. S.—Female; 42 years; married; has children. Her mother was said to have been psychotic. In 1907, she developed mental symptoms which cleared up in a few months. In 1913, she had another mental breakdown which lasted four years. For five years thereafter, she was considered perfectly normal. In 1922, she suddenly became excited and noisy. She was admitted to Manhattan State Hospital, where a diagnosis was made of manic-depressive psychosis. Physical examination revealed an enlarged uterus to the level of the umbilicus. For years, the patient had worn a pessary to prevent conception. A laparotomy was performed, April 20, 1923. The uterus was filled with a lipomatous mass, in the center of which was a wire pessary. Both ovaries were flattened by pressure between the mass and pelvic wall. Hysterectomy was per-

formed. Within five months thereafter, definite mental improvement was noted. In September, 1924, the patient was so much improved that she was paroled; and in April, 1925, she was discharged as recovered. Followup for several years thereafter revealed the patient to be entirely well. Then she was lost track of. (This case was reported in substance by R. G. Wearne, M. D. of Dr. Bainbridge's service. Medical Press and Circular, London, April 16, 1924.)

Case 9. M. S. H.—Female; about 45 years; single. She had a fistula in the left side, evidently the result of diverticulosis or abscess in the lower bowel. This was a constant source of strain. She became hallucinatory and was sent to a State institution, where she was confined for about 20 years. The fistula was open most of the time and exuded fecal pus; but permission for an operation could not be obtained. Believing there must be some foreign body present, I forced the point of operation and finally obtained permission. Surgical procedure revealed the prescence of a toothbrush in the fistula. The wound healed. After a short time, the patient was discharged, recovered both physically and mentally.

Case 10. C. C.—Male; 23 years; single. He consulted me in September, 1925. An abscessed appendix had been drained at nine years of age. For five years, he had had attacks of gas, pain, and bloating of the abdomen, with marked constipation. There was a loss of 37 pounds in weight during the year previous to consulting me. In December, 1924, without any previous symptoms, he suddenly became unconscious and had the classic symptoms of epilepsy. All laboratory tests which I had made were negative, except that X-rays revealed marked ileal and colonic stasis. The operation was on September 26, 1925. A kinked appenedix was removed; and many adhesions throughout the abdomen were relieved. In the year following the operation, after indiscretions in diet, he had three very mild attacks, since which time there has been no return whatever. He was graduated in excellent standing from college. At present perfectly well, with all mental symptoms absent, he is successfully following his profession of civil engineer. He was married in 1936; a normal child was born in September, 1938.

Case 11. R. R.—Male; 11 years. In August, 1932, the patient fell 15 feet from a roof and broke his right radius and ulna. Since then, there had been frequent vomiting; he was on a liquid diet, incapable of swallowing solid food. In February, 1933, he was brought to me from his home in Caracas, Venezuela. I had X-ray pictures taken which showed an area of constriction in the lower third of the esophagus, considered neurogenic in nature. Because of starvation due to vomiting and inability to swallow solid food, bone surgeons had difficulty in getting the fractured bones to knit. Marked pain developed over the appendix region. He was hospitalized, kept quiet, sedation treatment was given. Vomiting ceased; there was a gradually increased caloric intake from 55 per day to 1975. The broken bones began to knit. March 31, 1933, I removed the appendix, and the patient returned home late in April having gained 20 pounds. In June of that year, following some trouble with an automobile in which he had been riding for many hours, he again became unable to swallow solid food. Sedatives and quiet overcame the trouble. Since then, there has been no return of this reflex nerve spasm; and at the present time, seven years later, the boy, now a young man, is in perfect health.

Case 12. R. J.—Male; about 60 years. A famous author. He suddenly became unable to swallow enough food to maintain his strength. From 180 pounds, his weight decreased to 70 pounds. As a last resort, I was called in, and I decided to perform a gastrostomy. The first stage of the operation was performed, merely the preliminary

step of stitching the stomach to the abdominal wall; the stomach itself was not opened. The second day after the operation, the patient asked if he might try to swallow. Permission was given, and he swallowed with ease. The operation was never completed; for the patient had recovered completely, had no further difficulty in swallowing and lived many years thereafter. It was simply a case of nerve spasm of esophagus in a highly nervous, overworked man.

SUMMATION

In our march of progress from the darkness of a short term of years ago when barbaric cruelty was meted out to those sick of mind, let us be eternally vigilant to build upon the advances of the past 30 years. More humane care, less stigma, better classification, more success in prevention, earnest research along many lines, all mark blessed advance. Still there remain a million children in our country who will be mentally diseased; and today, as I have said, there are 500,000 mental patients in our institutions. Surely a great call to service urges us on today, as we prepare for tomorrow.

My whole plea is that we do not overlook the group—perhaps only small as far as our present knowledge is concerned—which surgery can save. Let us, then, from a scientific and humane standpoint, keep the following in mind:

1. To relieve whenever possible any obvious physical defect—malformations, scars, birthmarks, etc.—that may react on an individual's mental state. (Dr. Irving J. Sperber, dental surgeon at the Manhattan State Hospital reported a case of an inmate, suicidal, upon whom he had done excellent dental work, after which I had performed a plastic operation to overcome an extensive deformity, following surgical procedure for cancer of the lip. The man was able to be paroled some months later and to continue in the employment secured for him. Another manic-depressive, ever conscious of her breasts, which were so large and dependent that they extended down to her thighs, recovered completely from her mental pathology after I performed a plastic operation on the breasts and made them of normal size.)

2. To seek and adequately treat any physical pathology which may be the etiological factor in the mental derangement.

3. To relieve any physical pathology that may aggravate a mental or nerve condition, and detract from the possibility of recovery.

4. To remove in time, any physical condition that may develop in a psychotic patient, and which may get worse and cause suffering, such as tumors of the breast. (This will necessitate periodic examinations by a surgeon.)

5. To realize that from the cradle to the grave we are all—those of us incarcerated in institutions and those still at liberty—subject to all manner and forms of physical pathology. (Infants as well as those advanced in years understand the feel of pain. Under my care at the present time I have a man who was born on January 5, 1834, over 106 years ago. His life has been full and interesting. He is a little senile now, but he still enjoys detective stories, his whiskey which he has been drinking since the age of six years, and his tobacco which it has been his habit to chew for the past 75 years! His five score years and six did not deter me from operating successfully the other day for a large abdominal abscess, which otherwise would have caused general peritonitis.)

6. To remember, in short, that we are all of one family, the normal and the mentally diseased, and that much of the hope for the future of the race lies in our attitude "even unto the least of these."

34 Gramercy Park
New York City

Discussion at the Conference

The Chairman (Dr. William J. Tiffany): The discussion of Dr. Bainbridge's paper will be opened by Dr. Bellinger, superintendent of the Brooklyn State Hospital.

Dr. Bellinger: Dr. Tiffany, Dr. Bainbridge, ladies and gentlemen of the Conference.

I have listened with interest to Dr. Bainbridge's paper, which it was my privilege to read before the meeting.

In general, I agree with the various schools of psychiatric thought. The only fault I have to find, is with the attempt, on the part of some, to make one particular theory applicable to all cases. There is no question that the teachings of such men as Kraepelin, Freud, Meyer, Bleuler, Kempf, Jung and Adler have all been of fundamental value. Any criticism I would make would be of an attempt to make the various theories apply to all cases; naturally I also do not believe one can attribute the cause of all mental diseases to foci of infection or physical defect. I quite agree with Dr. Bainbridge, however, when he said that "some psychiatric cases are due to, and probably dependent to a considerable extent upon foci of infection or actual pathology." A survey of the histories of patients at the Brooklyn State Hospital during the past few years shows that a considerable number have been materially benefited by surgery.

One woman, who was admitted on April 1, 1938, when she was 38 years old, was depressed, worried, anxious, and appeared to be an early case of involutional melancholia. There was a history of gall bladder drainage

about one and one-half years prior to admission. Examination showed evidence of a chronic cholecystitis which was verified by X-ray examination of the gall bladder. After some delay, her husband gave his consent to an operation for cholecystectomy, which was performed in January, 1939. Immediately following recovery from the operation, she became more cheerful and began to improve mentally. Her improvement continued; and she was paroled in April, 1939, at which time she was in very good mental condition. She was discharged in April, 1940, as recovered.

We have had a number of middle-aged men who on admission to the hospital were found to have prostatic hypertrophy. Invariably they were depressed, worried and anxious, complained of insomnia and, at the time of admission, presented quite hopeless pictures. During the past few years we have operated on several of these patients, in some of whom there has been very appreciable improvement in mental conditions within a reasonable time after operation—in some instances to the extent that patients were able to leave the hospital apparently recovered.

As to foci of infection, particularly infected teeth, I recall that while at Binghamton I was called in consultation to see a woman who had been confined to bed for several weeks with rheumatism. She had a temperature of more than 102°, and, when I saw her, was anemic and very weak physically. Mentally she was in a delirious and confused state. I finally obtained the consent of her husband to remove her at once to the Binghamton State Hospital where she was admitted on a health officer's certificate. It was necessary to stimulate her; and as she was dehydrated, she was given hypodermoclysis and glucose intravenously. Her teeth were found to be badly infected. These were gradually removed, with the result that she gained in weight; her mental symptoms disappeared; and she was paroled from the hospital apparently in excellent mental and physical condition about eight weeks following her admission. Unquestionably, this woman's mental condition was due to her badly infected teeth.

I have seen many other cases in which infected teeth have been a definite etiological factor. I am convinced that all patients admitted to State hospitals should, immediately following their admission, be given very thorough physical examinations, that their mouths should be carefully examined by competent dentists and records made of the findings; that when infected teeth are found they should be immediately removed, and that nothing should be left undone to put the mouths of all patients in the best possible hygienic condition. In this connection, too much dependence should not be placed upon dental X-ray findings, as the X-ray does not always show infected teeth. Any physical defect should, without delay have such medical and surgical treatment as would seem to be indicated.

I am convinced that it is our duty to do everything in our power to place all of our patients in the best possible physical condition, for by so doing we will cure some patients of their mental illness and those whose minds are not improved will be made more comfortable.

I feel that it has been a privilege to have been able to listen to Dr. Bainbridge's very interesting paper.

THE CHAIRMAN: Dr. Bainbridge's paper is now open for discussion.

DR. WEARNE: I would like to say a few words about my experience at Ward's Island assisting Dr. Bainbridge on the surgical service. He was a most enthusiastic and indefatigable worker.

I agree with his statement concerning the necessity of treating mental disease by first correcting all important physical disorders. I recall a particular female patient who was about 45 years old. She had been in Manhattan State Hospital a number of years. Her psychosis started with worry over the presence of an abdominal tumor and later passed into a depressed agitated state. Her brother was a gynecologist; and, although before admission our patient was examined by several different physicians, no one found any pathology. About three years later, during some routine pelvic examinations at Ward's Island, this patient was found to have an ovarian cyst. She was quite dehydrated, weighing less than 100 pounds. However, following the excision of the tumor there was no mental improvement, and she continued dull and deteriorated. I have often wondered, if the presence of this tumor had been discovered earlier, if her psychosis might not have been prevented.

Another interesting case was that of an employee who was a boat captain. He complained of pain in his abdomen whenever an unusual amount of strength was required to manipulate the boat's steering wheel. Later, gastric complaints were superimposed. When seen, he was constantly talking about his discomfort and was fast passing into a neurasthenic state. However, following a herniotomy by Dr. Bainbridge his condition improved. When I last saw him I asked how he was, and he replied that he had never felt better in his life. His whole personality was changed.

There is no question that sometimes the somatic factor plays an important role in mental disease.

DR. LEWIS: Dr. Bainbridge wrote me requesting that I say a few words about his paper. I think we all agree with him definitely that this particular group which he describes needs special attention. It is a sort of adage nowadays in psychiatry; and there has been an attempt to work it out scientifically, that we should attempt to discover and try to correct all physical diseases in a mental patient, by any available method known to medicine, surgery or laboratory, as soon as such condition is found. Regard-

less of whether the physical disorder plays an important part from the standpoint of etiology, it certainly places an extra load on the patient, and thus complicates, retards or prevents recovery.

Now when we study patients for causes of their disorder, we take into consideration the whole person, including the constitution, the development of the situation through the life of the patient, and the personality of the individual, and try to determine the different points of instability. There are different degrees of stability among individuals. For example, some become delirious from very slight disabilities. Some even become so from severe toothaches. They become a little out of their heads for a day or night, or longer, when they have fevers. Others can stand a great deal of toxemia without showing any delirium; and so we have these different degrees. I have seen a serious delirium precipitated by an abscess on the heel, while the average person would not be affected mentally at all by such slight lesions. So we find in our patients many different degrees of toxin sensitivity. On the other hand, a good many people with serious surgical or medical conditions do not not develop any form of mental disorder. In others, these conditions precipitate definite psychoses.

So we come to a common ground where there are certain conditions, the removal of which definitely cures, or improves the mental state. Psychiatry is definitely a part of medical practice.

It is said that many years ago Dr. Starr stated in one of his classes that psychiatry could very well be taught in three or four lectures. He stated that he felt psychiatry was largely an oratorical subject. This certainly is not true, today, nor was it then, as far as my opinion is concerned.

After all it is very stimulating to know we are all working in medicine toward the same end, namely the improvement, cure and prevention of mental disorders.

THE CHAIRMAN: Is there further discussion?

DR. WOODMAN: Dr. Lewis has just touched upon one thing that I thought about as I heard the paper, viz., that this is a splendid paper to read to us psychiatrists who may be overlooking the physical side of the situation but should be kept out of the hands of many of the surgeons who are all too ready to find what they hope are the physical causes of mental disturbance and to cut them out. We are all getting patients who have been operated on over and over again, in some instances with benefit to their incidental disorders; but in other instances, with their removable organs gone and their kidneys sewed up, and worse after every operation.

DR. SMITH: I am glad to have been here today to listen to Dr. Bainbridge's most interesting and instructive paper. He has given it in his usual clear and terse manner.

I was first associated with Dr. Bainbridge in 1905 at the Manhattan State Hospital. Since then he has seen a great increase in the development of surgery in all the institutions, despite the fact that we formerly had poor equipment with which to work. He was always very conservative in his viewpoints.

I can recall the time when the theory of focal infection was quite prevalent; and a great many teeth were pulled out; and still the patients did not get any better. We do know, however, that a great many of the somatic diseases have an effect upon the condition of patients and in many cases are the predominating factor.

I well remember one woman who was suffering from a depression and was irritable and very nervous. She came to our hospital. They could not do much with her at home. We had her examined; and she was found to have a large laceration, which gave her very poor control. As a result, she withdrew herself from society and became very depressed. She would not go anywhere and became extremely nervous. I really think this laceration was a very important causation in her psychosis. As I have said she was examined; and, at that time, surgery was decided to be necessary. She was operated upon and the laceration repaired, with the result that she was much improved. She said, "Now I can go out again among people and feel I will not be embarrased in any way."

I think we can go too far in ascribing everything to a physical basis. That is why I feel that the development of our diagnostic clinic is a great step forward in the treatment of patients. I feel we have an excellent hospital staff at Manhattan, as well as a consulting staff; and patients who are sent there can be examined and treated for any somatic disease which they may have. Perhaps, it may be the teeth or some other physical ailment.

As Dr. Bainbridge has mentioned, I feel we should have all patients thoroughly examined and see what is actually wrong with them, and then correct the conditions as far as possible. You will find perhaps, in a good many cases, delusions that can be overcome by the correction of the physical condition.

Again, I wish to say that I am very glad to have been here today to hear Dr. Bainbridge's paper; because he has called attention to facts, and he has treated the subject from the psychiatric viewpoint, as well as from the physical and medical viewpoint.

In regard to his reference to Dr. Starr, I was present at that meeting on psychoanalysis. At that time, psychoanalysis was thought to be a cure for

many ailments. I think it was pushed forward too much. I remember when Dr. Starr said an ounce of Muldoon was worth a ton of Freud.

THE CHAIRMAN: Is there further discussion?

DR. KNAPP: I am very glad to have the opportunity of being here today and of hearing such an interesting paper as Dr. Bainbridge has presented. Of course, I feel there are two sides to the question.

It is most desirable to have a thorough physiological examination of the patient. This defines the type of case better and points the way for us to be on the alert for abnormal physical states which need correction and possible surgeial interference.

In our psychological zeal, perhaps, we sometimes lose sight of the fact that in every case of mental disease there is disease of the brain, and often of the body, as well as of the mind. Sometimes abnormal physical states are easily diagnosed, often they are obscure. If found, they need to be treated, if we hope for the patient to recover.

Some years ago it was my privilege to be called to care for a ward in which there were a large number of disturbed patients. I found them suffering from various abnormal physical conditions, mostly toxic states, gastro-intestinal abnormalities and circulatory disturbances. Others stood in need of surgical attention. These conditions were corrected, and the ward became comparatively quiet. If such cases are neglected, many of them will pass on to chronicity. However, one should not be satisfied with one course of treatment, but be on the alert for a recurrence of the condition and then repeat remedial efforts.

The so-called functional mental disorders are very fluctuating affairs. The spontaneous tendency to recover, at least, temporarily, is much greater than was formerly assumed. Because of that, it would not be fair to say that any recovery of a functional psychosis, following surgical or medical treatment, can be entirely attributed to that. We also know, from our experiences, that very often an acute physical illness or an operation on a schizophrenic or manic-depressive individual will lead to a recovery or marked improvement. This, I suppose, can be evaluated as some form of non-specific shock treatment. It is possible that the underlying mechanism is somewhat similar to that of many of the different shock procedures.

Dr. Bainbridge's patient, aged 106 years, who drank whiskey from the age of six, is most interesting and instructive. Individuals generally do not realize that alcohol is a medicine and not a beverage. When it is made a beverage and then indulged in continuously, the trouble begins. In my experience it has always seemed that there are two types of individuals who

are in danger—the total abstainer and the habitual drinker. The type of person who may develop a true vesania, that is, one devoid of any recognizable physical disorder, may show, during his lifetime, swings in bodily health in which exhaustion plays a part. This type of person may be benefited by alcohol moderately at times. The alcohol will be oxidized in the system and take the place of food. Also, the sedative effects may tide over periods of difficulty.

The psychological interpretations of the functional psychoses are so overstressed that it is gratifying to hear papers presented by non-psychiatrists who try to give us the other side of the story. With due consideration to all the psychological phenomena which are able to produce mental disorders, it is important to mention that the lowering of the resistance of individuals through some somatic disease makes them more vulnerable to psychic injuries.

I am sure that we have all been greatly benefited by the admirable recital of Dr. Bainbridge's experiences.

THE CHAIRMAN: I regret that our time is passing and that we should proceed but before we do so, we would like to give Dr. Bainbridge an opportunity to respond to all of the discussion which his very fine paper has provoked.

DR. BAINBRIDGE: On entering the hospital just now I noted a large marble tablet which stated that this hospital was opened in 1873 as the Middletown State Homeopathic Hospital. This brought to my mind something that may be of interest to you.

My grandmother was the fourth woman on this continent to study medicine. She had the greatest difficulty in getting admission into a medical institution, as the doors were largely closed to women. After being graduated in 1860, she went home to Cleveland and later became the first dean and the first president of a homeopathic woman's medical college in the United States. She introduced the first electric bath in the Middle West, fastening electric wires to the bath tub, and experimenting on my own mother. She never hung out a sign; her work was principally with the factory girls of Cleveland, doing what she could to help the employees of her husband, John Seaman. When she sought out the minister who had baptised her own children—she was then in middle life—and sent in her card, he declined to see her, saying, "I refuse to receive any woman who has so unsexed herself as to study medicine." How things have changed between then and now!

First, I want to thank those who have so kindly enriched my paper by their discussion. Often a paper at a medical meeting is a small part, as we all know, of its real worth, and the discussions add immeasurably to its value.

I have been actively engaged in the State medical service for upwards of 30 years, and the improvements which I have seen have been most marked. With my interest in mental hygiene from undergraduate and post-graduate days, at home and abroad, I have been very proud to see the advance that has been made in the State of New York in the care of the mentally sick, and I want to congratulate our present commissioner and those working under his efficient leadership. This has been a most complicated problem, with great financial handicaps, and Dr. Tiffany says there is a large enough yearly increase in cases to fill a 2,400-bed hospital.

I trust that any one who feels I am an extreme advocate of radical surgery will read my paper very carefully; they will see that I am rather a progressive conservative. You will note that in my paper I mention a case which Dr. Wearne and I had at Manhattan State Hospital many years ago. This was of such special interest from the surgical standpoint, as well as the psychiatric, that a report of it was published in the London Press and Circular and had wide circulation throughout hte British Empire. The removal of a large uterus with a fatty, intrauterine tumor, surrounding a metal pessary—with conserving of the ovaries—resulted in complete relief of the mental symptoms; and the patient remained well for many years.

Today you are emphasizing the prevention of mental conditions, making progress in their classification, and doing a great deal of research work, especially in the field of shock treatment.

The following lines of investigation have interested me; and some of them have already received attention. They are worthy of most careful study, and may clear up some of the unsolved problems which have relation to somatic conditions, and, directly or indirectly, be factors in mental and nervous conditions:

First: Conditions of the body fluids in relation to internal irritation of the cells of the body. Second: Endocrine glands and the hormones, change in quantity and quality. I am using hormones in the treatment of certain mental symptoms, giving the opposite hormone in connection with a number of the explosive sex trends and overacting glands. Third: We have deficiency diseases of the body as a whole; may we not have deficiency diseases of parts of the body? Professor Pierre Delbet, head of the Medical Department of the University of Paris, has done certain pioneer work along this line. He believes there are deficiencies of calcium, magnesium, iodine and other elements, and feels that we should have more of them than

our ordinary food contains; and a further supply of these is especially beneficial in middle life and older years. Iodine is already being added by law, in certain places, to our table salt; and in some cities certain chemicals are being incorporated in the public water supply.

There is also the question of luetism, referred to in my paper. This is a "thinned-out" lues, a taint not passed by contact, which does not react to any known serological test, but which can often be discovered, in attenuated form, through noting bony changes, which may reveal this as a possible factor in other pathology.

With these and others, there is a very wide and may we say promising, field for earnest research, one holding out hope for the poor unfortunates who are sick in mind and body.

FIVE MONTHS OF FAMILY CARE OF MENTAL PATIENTS

BY ETHEL B. BELLSMITH

On July 1, 1940, The Central Islip State Hospital was notified that funds were available through the Department of Mental Hygiene for the placement of State hospital patients in private homes for family care, at the rate of $5 or $6 weekly. Consideration led to the conclusion that possibly 50 patients might be placed in the first year.

The matter was approached with some trepidation, and with wonder if the community would welcome psychotic individuals into its homes. As a means of learning the attitude of responsible people locally, the social worker visited priests, ministers and postmasters in six towns within a radius of 20 miles. All were interested; some were doubtful; one frankly said he considered the plan impractical at the rate of board allowed, suggesting $8 weekly as a minimum. Several pastors promised to inquire among their parishioners and to discuss the plan in their women's societies. As there are few farmers in this hospital's immediate vicinity and as the State's rate is much less than the usual rate paid locally for boarders, which is $10 to $14 weekly, those with whom the plan was discussed were not too optimistic.

The first direct appeal was to one of Central Islip's retired physicians, who immediately agreed to take two women—and several more if these two adjusted well. The local postmaster suggested a married couple— two retired Central Islip employees—who were seen the next day and readily agreed to take one woman and possibly another. Within a week, four patients had been placed and the increase has been steady and consistent. By August 1, 15 had been placed. On August 30, 42 were in homes; and 12 had been approved for placement, with homes ready to receive them, on the first Monday in September. On October 1, there were 73 patients out in homes, and 11 more homes had been investigated and accepted.

It has seemed wise to take the patients out of the hospital and to make changes in home placements once a week, on Mondays. This is the most convenient day for the department and the hospital, and the practice makes the records fairly uniform. Occasionally, it has been necessary to deviate from this to return a patient; but, on the whole, it has worked efficiently.

Patients were suggested to social service by the physicians, ward employees, stenographers, even by other patients. If those suggested were considered suitable, they were recommended by the clinical director or the first assistant physician to the superintendent for approval. Many conferences were held; and only those patients were placed as to whose

suitability the physicians and social service department agreed. The ward personnel were particularly interested; and without their whole-hearted cooperation and kindly, intelligent suggestions, the results could not have been so rapidly and successfully obtained. Even to the social worker in charge of the department—who has had many years experience of the interest and devotion of the ward personnel to their charges—it was an amazing illustration of unselfish zeal and eagerness to help the patients and the department. Inquiry was made of each patient seen as to whether he had a friend or knew anyone on the ward he would like placed with him or in another home. All patients suggested were interviewed. If not approved, an explanation was given as to the decision reached. It was felt wiser to see many whose possible adjustments were questioned in advance, rather than to miss one patient who might be suitable.

Apprehension as to the attitude of the communities, small rural towns of from 2,000 to 5,000 population, proved unfounded. Applications came in steadily. The day after the visit to the home of the retired Central Islip employees, a neighbor, a retired practical nurse, called to inquire. She was followed by the wife of a local tradesman. A visit was paid to a local boarding house for men, one of excellent standing, operated for over 40 years. The owner, "Ma Johnson," consented to take two men on trial, to be followed by more if the plan proved satisfactory. She now has eight men. Visits continued to local people who might give leads to others, with interviews with anyone suggested, even though the outcome seemed doubtful. One foster home mother suggested a neighbor who had cared for her grandmother until the age of 91. "She likes old people. If you could give her an old lady, I'm sure she would be pleased." It was possible to do so, and the patient made an excellent adjustment.

A call was paid on a minister, formerly of Central Islip, now in another parish two counties away. He responded at once by taking one woman, who is very happy; and he will take another when a suitable one is found. Great efforts have been made to find homes to suit individual patients and patients to fit into individual homes. In this case, the selection was a refined, intelligent woman, 67 years old, with a hospital residence of 22 years. She attends church and the moving pictures. The family took her to the World's Fair and has purchased new clothing for her. She has a spacious room, eats and mingles with the family as a respected member of it, and meets the parishioners. After three months, she continues to adjust very well. Another interesting patient is Isabel Jones, trained nurse, diagnosis paranoid condition, aged 66. She has been placed with a physician's family, answers the telephone, receives the doctor's pa-

tients, takes some responsibility for the other family care patients in the home, and has a very important place in the world, both in her estimation and in that of the family.

The homes represent a number of types. They are selected with regard to the interest of the person who made the application and with regard to the evaluation made of the home and the family. The physician, minister and the woman in charge of the men's boarding house, were old friends of the hospital staff. When they were approached, their aid was counted on; and it was generously given. Five retired practical nurses applied and are giving excellent care to the women patients placed in their homes in groups of from two to six. There are only two farms among the homes, one a dairy and the other a chicken farm. The owners of the former care for six women; and those of the latter have two men. Of the remaining types, one group needed the patients and applied for them; the other was recommended by the Negro minister in a large town six miles away.

In speaking of needing the patients, the woman who needed a grandmother has been noted. Others are a crippled woman living alone who needed company; a young woman, born and brought up in the hotel business, who needed people around in her large, comfortable home where she was alone all day; the wife of a local tradesman who had an exceptionally good home and wanted someone to help her in the mornings.

There is the family who lost their home in the depression and moved out in the country to a 12-room house on a large estate which they rented at considerably less than a house in town. They needed some elderly men for company, to fill up the house and to earn some money. The eight old men, two each in a large double room, never lived so handsomely. They wander around the grounds, dig a little in the garden, reminisce under the apple tree and enjoy life on a scale unknown to them before. Arrangements have already been made with the county office of Old Age Assistance to investigate any such patients who may later be recommended for parole. If they qualify and are paroled, they will receive old age allowances in their present homes. This will release family care funds for the placement of other patients.

The homes for Negro patients were recommended by the minister of a local Negro church, and the owners' cordial acceptance of the plan and of the patients placed with them, as well as the lack of friction and the ready adaptability of the patients and caretakers, have all been impressive. As one hebephrenic dementia præcox patient said, "I just take it easy;" and he held the storm door for a paranoid patient to hang. There are six homes for Negro patients, with from two to five patients placed in each home. The foster mothers know each other and live within a radius

of three blocks so that the male patients visit each other at intervals. All Negro patients attend the local church; some go to the weekly Bible class; and one sings in the choir. The pastor recently addressed them from the pulpit, indicating his interest in their welfare and urging them to come to him at any time of anxiety or difficulty. He assured them that all were working for their comfort and would see that they were treated fairly. One female patient is making a very satisfactory adjustment; and, as soon as her parole* is approved by the medical staff, the minister will find a suitable position for her.

The readiness with which many elderly patients—in the hospital for a long period of years—adjusted was surprising.

AGES OF PATIENTS AT TIME OF PLACEMENT

Ages	Number placed
Under 40	16
40-50	21
50-60	42
60-70	34
70-80	18
	131

Long and continuous hospital residence proved to be no obstacle to placement.

LENGTH OF HOSPITAL RESIDENCE BEFORE PLACEMENT

Years	Number placed
1-5	62
5-10	44
10-20	10
20-30	9
Over 30	6
	131

Among patients who adjusted most readily, the older groups of long hospital residence, with somewhat dulled affect, appeared to have the fewest difficulties. They were the least demanding, required less follow-up, had fewer needs. The possibility of family care was discussed with William Webb, aged 74, who had been in the hospital 38 years. He objected to

*A patient may be paroled to a relative or other person for a period which is ordinarily a year. During that time, the patient remains under supervision and observation of social workers and at the end of that time, if his condition warrants it, he is discharged. The institution paroling a patient is not liable for his expenses while on parole; and the rules of the Department of Mental Hygiene provide that no person shall be permitted to go on parole "who, in the judgment of the medical superintendent or physician in charge, is homicidal, suicidal, destructive or dangerous, either to himself or others."

leaving unless his children could be located. Although they had not visited the hospital at any time; and although his mother, who had come to see him up to 1923, had died; efforts were made to learn the children's whereabouts through various churches in Brooklyn. The children were not found, but the patient was seen again; and after thinking the matter over, he decided to try out the plan if he could be near a Protestant church. He was placed with several other men in the home of a Central Islip retired supervisor and taken to the local Protestant church on Sundays. He soon expressed dissatisfaction; the church was too small, the Methodist church would be better, the home was too large. After several weeks an elderly couple who had a small compact house were found. They were in a larger town near a spacious Methodist church. The patient liked everything immediately and after three months is contented and helpful. "He rakes the leaves up before they fall to the ground," and keeps the front yard neat and tidy. Many other patients, inspired by the immaculate care maintained in the institution and the habit-training in ward routine, have been of definite help in their foster homes in tidying up homes and yards, caring for pets and planning small projects of benefit to the family.

Of 138 patients taken out for placement, seven returned the first day, refusing to enter the house or having entered, refusing to stay, saying, "This is not for me—this is not my home—I do not belong here." This indicated that these patients knew their own needs best; and they were returned immediately. At no time, was pressure placed on any patient to leave the hospital for family care or to remain in a home in which he was discontented.

It was considered important to place a patient as soon as possible after approval by the superintendent, within a week if it could be arranged. Deferred placement might reduce the patient's interest in the plan, increase his anxiety or lead to doubts as to whether he really wished to go. It was also thought advisable to place a patient in a home shortly after it had been approved. Acting when the persons involved are interested and ready makes for more harmonious relations and better outcome.

At best, each placement is an experiment; and the aim has been to increase the favorable factors and reduce the unfavorable ones to a minimum. Care was taken to place a "good" patient first; and as the foster home mother became more understanding, more aware of the implications of mental illness, to place another not so "good." The patient who is in good contact with reality may help the less fortunate one and derive satsifaction from it. Patients who knew and liked each other were placed together when possible. A few patients who developed dislikes or antagonisms to other patients, to members of the home or to the type or location of the

home, were removed to other places. The second or third placement is often highly successful. "This is what I wanted," says the patient; and, while this does not indicate a settled future, it augurs well for the present.

The homes used at Central Islip vary in location from those right in the heart of the town to those out in the woods. In size, they range from spacious mansions to six-room bungalows. They are maintained by professional persons of assured incomes and social position, by successful business people, by persons who have weekly earnings sufficient for their needs and by retired individuals on pensions. Accessibility to a church of the patient's faith is required if the family is of different persuasion. Patients are not placed in the homes of present employees, as the hospital does not wish to be involved in several financial transactions and different relationships with single employees, although it is recognized that an employee's understanding and training would be valuable assets.

Of the 131 patients, placed between July 1 and November 30, 29 returned after varying periods; five were paroled; and 97 remained in family care. Of the five paroled, one escaped from supervision, three were placed in positions with wages in addition to maintenance, and one was taken home by relatives.

The reasons for the return of 29 patients included both exacerbation of mental symptoms and physical illness too serious to be treated in the home. Among the mental symptoms were: Over-activity, constant complaining, periods of confusion, noisiness at night, disagreeable and threatening attitudes, acute episodes, dirty personal habits, threatening or attempting to run away.

The 97 remaining in family care at this time will be regularly reviewed to discover any parole possibilities. The cases of five of these 97 are considered parole possibilities and are being studied. It is expected that final arrangements for them may be made early in the new year.

The diagnosis of patients placed in family care did not appear to be an important factor. The largest number of patients placed in any given classification was that of dementia præcox, probably due to the preponderance of that group in the hospital population.

DIAGNOSIS OF FAMILY CARE PATIENTS

Diagnosis	Number placed	Diagnosis	Number placed
Dementia præcox	63	Senile psychoses	5
Cerebral arteriosclerosis	20	Paranoid condition	3
Alcoholic	14	Traumatic psychoses	2
Mental deficiency	8	Involution melancholia	1
Manic depressive	7	Psychoneurosis	1
General paresis	6	Psy. with psy. personality	1

Summary and Conclusion

In summarizing the results of this brief period, several factors emerge as important elements in the success obtained:

1. The interest of the staff and employees in furthering the plan.
2. The eagerness of the community in cooperating with the hospital.
3. The active search for and consideration of a large number of patients, who were recommended from every possible source in the hospital.
4. The careful selection of patients for placement.
5. The choice of the home best suited to the particular patient, and of the patient for the specific home.
6. Flexibility in making new plans if the first or second placement was unsuccessful.

The following points seem worthy of emphasis:

1. The ready adaptation of individual patients to complete changes in their modes of life.
2. The evidence that suitability for placement is not dependent on the type of mental illness.
3. The adaptability of the older age groups to family care.
4. The educational value resulting to the community.
5. The willingness of social agencies to participate.

The plan is to continue to place patients carefully and slowly. It is anticipated that the higher the number placed, the greater will be the percentage of patients returned to the hospital. As an increasing number of promising patients are placed, and as they improve and are paroled from family care, the possibility of finding other suitable patients in the hospital is correspondingly decreased.

The follow-up of patients in family care is time-consuming and concerned with many small difficulties and problems. The physical requirements include seasonal clothing needs and replacements, hair cuts and shaves, and such matters as minor ills, eye examinations and dental care, which require prompt attention. Emotional and mental reactions, such as misconceptions on the part of the patient and foster mother, disagreements and jealousies between patients, morbid fears, apprehensions and anxiety, demand immediate and expert treatment. Increased understanding and improved relationships come only as a result of unremitting patience and skill, and of the expenditure of much time and energy. In spite of intelligent planning and efforts to anticipate situations, emergencies

constantly arise and obviously are not confined to office hours. Up to the present time, there have been no serious accidents or situations which could not be readily handled.

At Central Islip State Hospital, experience leads to the conclusion that family care is a practical and beneficial means of treatment for many different types of patients. For a substantial number it will lead to improvement, parole, and eventual discharge.

Central Islip State Hospital
Central Islip, New York

SOME THOUGHTS ON FAMILY CARE*

BY PERCIVAL H. FAIVRE, M. D.

This paper might aptly be titled, "a flight of ideas of a family-care doctor."

Back in 1935, when Dr. Woodman informed me that he was placing me in charge of the family care program of the Middletown State Homeopathic Hospital, I was quite elated but when he added that we would be allowed approximately four dollars a week to board patients out in private families, I thought it rather a dubious honor.

On the second day of July, 1935, when the hospital social worker placed two patients in family care, I did not ask how she accomplished this. Privately, I suspected that she must have threatened the house mother or had failed to quote the weekly rate.

Nevertheless, by the end of the first month a real start had been made, with 14 women placed in family care by this hospital. By the end of the first fiscal year, 86 patients were in family care, and more than half were living with families in the valley of the East Branch of the Delaware.

The new homes offered for family care now come to us voluntarily from persons who have become acquainted with the program though contact with established family-care homes. Resistance to the idea of placing hospital patients in outside communities has to be broken down before the program gains momentum in any region.

When an application is received, we endeavor first of all to obtain some knowledge of the family through our home parents and from people of good standing in the community. Storekeepers, and other representative people know the character and reliability of most of the prospective families in their neighborhoods. This information is kept confidential and as far as I can recall, has been quite unbiased and reliable.

Then comes the inspection of the home—first of all location. Experience in winter driving has taught us that homes on the main and secondary roads or in close approximation to them, are best, for they can be easily reached in emergencies in any kind of weather. Then cleanliness is paramount. Some of our homes cannot be termed palatial, but they are all clean and well kept. Investigation is made for fire hazard. We have made it a rule to accept no place where a patient would have to sleep above the second story of the home. In some cases, where necessary, we have suggested hand-rails on stairways and in case of low windows, a wooden bar

*Read at the quarterly conference at the Middletown State Homeopathic Hospital, September 21, 1940.

across, to prevent the possibility of patients toppling from them. Modern conveniences are sought, but in some cases we have utilized homes without all conveniences where the promise has been made to make improvements. Promises have been kept in all instances.

After selection of the home, the house mother has been instructed as to her responsibilities to both patient and hospital, i. e., in case of accident or sudden illness, she is to call a local physician and notify the hospital immediately by reversed charge telephone message. Minor happenings are to be reported by letter. In case of escape, the local authorities and State troopers are to be notified. At this point I might commend the State police in the Delaware region for their cooperation in matters concerning our family care patients. Interest of the State police is important when patients are placed far from the hospital. We have made it a rule to notify the local health officer and State police that hospital patients were being placed in their districts.

There has been much variation in opinion as to the type of hospital patient to be placed in family care. Some feel that the chronic deteriorated patient who is fairly clean, and who would be a life-long hospital resident, is the one we should make an effort to place in the private home.

I must be frank and say that we have successfully placed some of this description. There has been some mental improvement in most of them. However, I cannot but feel that they still are institutional problems and not good family care material. This type retards the growth of family care.

Then there is the more elderly, well-controlled patient who is thoroughly institutionalized by long hospital residence. This type of patient, after family care adjustment, appears content and happy and enjoys a normal home life. This group affords a number of both men and women in the higher age brackets an opportunity for adjustment in private homes and for enjoyment of living outside the hospital. After the experience of the past five years, I cannot feel that advanced age is any bar to family care, as long as the individual is able to look after his own needs and is in a fair state of physical health. This older group is acceptable in most of our family care homes and can enjoy the comfort that such homes afford.

There is still another—usually a younger—group of patients whose psychoses have more or less burned themselves out. They are not very deteriorated, but have enjoyed the security of the hospital long enough so that a break from hospital routine creates a condition of panic, because they are uncertain about a return to normal living.

This last group is one that we have wanted to be able to work with but have had little opportunity to place. Many of this group could probably be paroled after some time in family care. Others could get into private

employment after regaining some confidence by being outside the hospital.

In going over a great many case records of prospective patients for family care, we have picked as suitable those who have shown no real assaultive tendencies for the past few years. Those who have—even in the remote past—shown any sign of sexual or homicidal tendencies, have been eliminated. We have tried to avert, as far as we can, happenings that might disrupt the program.

The taking of a worker for placement in family care has been more or less frowned upon. As a staff member I can fully realize this viewpoint but feel that it should undergo some modification. There is no doubt that a tendency exists in the ward personnel to build up a reserve of ward workers. They usually have a little Dutch boy to plug the dike when needed. The judicious taking of a ward worker here and there necessitates an effort to train another, a patient who is usually idle. This is a good thing, not only for the patient and hospital, but for the ward personnel as well. If working patients express a desire to go in family care, they most certainly should have the opportunity.

Occupational therapy would seem to be an excellent adjunct to the family care program. Instead of retaining a quiet, clean patient who is an occupational worker, I think we could place more of this type in family care. If such patients' work is indispensable to O. T., arrangements could be made to have some of it carried on in the family care home. Here again, benefits for the hospital and patient are obtained by the necessity of training other patients.

Our greatest difficulty has been the absolute refusal of good family care prospects to leave the hospital. Just this week a woman refused; but after she had a vision, telling her to try family care, she decided to go to one of our homes. We have little control over visions, but it does seem that some way could be found to modify the desire to remain hospitalized. I would like suggestions on this point. Should we whisk them off to homes without the desire to go? This seems inadvisable. Is it permissible to foster a desire in some of these people by the curtailment of some of their hospital privileges?

If family care is of as much benefit as we believe to be, to patient and hospital, then I feel we are entitled to use some means of persuasion, such as those mentioned.

Recently we have tried giving instructions to ward charges to have the patients ready at definite times; then we have calmly placed the patients in the car and informed them of our plans. That has been somewhat more successful than the previous way of extending a cordial invitation and having it bluntly refused.

We always inform our patients that if after a fair trial in a home they are unhappy, they will be returned to the hospital. Seldom, after a few weeks' stay outside the hospital is this desire voiced. The majority of patients returned for one reason or another have expressed regret at leaving family care.

I don't know what is done in the other hospitals as a rule concerning the part of the medical staff in this program, but my feeling has been that an effort should be made to acquaint the individual staff members with the actual working of the family-care program by trips into the field to see family care as a concrete thing and not just as a name. This I am sure would stimulate the search for suitable patients. Some of our staff members have been most helpful. Some services, I must concede, have little available family care material but each service can most certainly find some suitable cases. If the hospital staff is not family-care conscious, we start with a great handicap. I offer this not as a criticism but as a suggestion.

The ward personnel must be considered as a very necessary part of this program and an effort should be made to acquaint them with their responsibility in finding suitable family care patients. A few of our patients have been obtained through their efforts.

A healthy spirit of competition in our department is a good thing, but we must not lose sight of the fact that family care belongs to all of us whether we actually place the patient or act as a source of supply.

Some hospitals are so situated that a family care program is a difficult attainment. This, I presume, must be true of some of the larger metropolitan hospitals. These could transfer suitable patients to hospitals more fortunately situated for the development of family care.

In up-State New York, there are innumerable districts that can afford the same opportunities that we have in Delaware County. A little missionary work and some information in the small country newspapers about the program as we already have established it, will, I am sure, afford the same opportunities in other sections of the State.

As soon as patients are available in our district, I am certain that acceptable homes will be found.

I have been asked to mention a community center. In a village or community with a suitable concentration of patients, within walking distance, there might be a great deal of merit in a center where patients could enjoy a radio, reading, games, the distribution and collection of O. T., work, etc. Such a center also has been mentioned as a place where an ill patient could be cared for temporarily, physical checkups could be made, etc. Many of our patients, however, would not be able to use such a place now, as many of the homes are miles from any possible place of location; and, especially

as under the price paid for family care at this time, I do not feel we could expect a family to transport patients back and forth frequently enough to warrant the expense of such a setup. I myself prefer to see them in their home environments for physical examinations and interviews.

The family-care patients I am sure would enjoy a slight increase in spending money, rather than the formation of community centers.

Mention at previous times has been made about the cost of the personnel used in the operation of family care. The amount of time used in the formation of a service of this kind, I feel, is not a good rule to measure by. A new program must necessarily entail a great deal of ground work—the transportation needed in starting this program has been a tedious, tiring thing—and the job took much time. The amount of work needed after the program is in full swing is the only honest measure of the amount of attention that is needed. There will be at first some overlapping of territory, with resultant increase in personnel costs and travel expenses; but this can be successfully worked out by the formation of districts that do not overlap.

Family care to me has meant the placing of patients within the confines of a normal household. After adjustment is made, both Mrs. Osborne, the Middletown State Homeopathic social worker, and I have concluded that, while we must keep an active grasp on the problem, the less we interfere by too frequent visits the better for the patient. We are well aware that some of the homes need more frequent visiting. New homes, we visit at fairly frequent intervals; and as we see things going along in harmony we have tapered off our visits until some families are visited only at fairly long intervals. Then we make the visits at unexpected times, usually calling at one or more of the homes at meal times to be able to check the food as to quality and quantity.

Another innovation—if we may call it that—which we have worked out is to have a few vacancies in family care homes so that if patients must be moved quickly they rarely are returned to the hospital. We can retain most homes with one or two vacancies; but if we tried to hold a home indefinitely on the promise of patients at a future time, the home frequently would be lost to us when we needed it.

The manner in which Delaware County area has opened up to family care, I think, justifies the distances we must travel from the hospital. To be sure, homes near the hospital are ideal; but disregarding distance, Delaware County has been our most successful area. Counting the patients of Letchworth Village and our own in that section, we have an excellent start; and I believe we have just started to utilize its possibilities.

One more suggestion before closing: In five years of transporting patients about the country, distributing clothing, and moving ill patients,

Mrs. Osborne and I think that the ideal means of transportation would be a good station wagon. The greater number of patients that could be carried at one time would be a great time saver. The removal of the seats would leave an excellent delivery truck for the transportation of supplies, which becames a greater problem as family care grows. With some modifications, a stretcher case could be carried in comfort and ease, if it were necessary to return a patient to the hospital for treatment.

Family care patients have as much chance for parole as hospital patients. We constantly look for prospective parolees; and with more suitable patients, this ratio would increase.

When Middletown gets its accepted homes filled—and we hope for that this fall—we shall have approximately 5 per cent of our patient population in family care. I feel that 7½ per cent may be attained and have hopes for possibly more.

Optimism and desire for the accomplishment of this family care program should not defeat good judgment. A slow, steady growth, with suitable patients, will be better than a speedy one with unsuitable patients and with resultant unpleasant happenings that would interfere with progress. So far at Middletown, only minor things have occurred and these have not been detrimental to the program.

Family care is already a sturdy, five-year-old child. It did have a bad time with financial malnutrition last year; but that has been relieved with the new setup, so let's all help raise it to a healthy maturity.

Family care is a success.

Middletown State Homeopathic Hospital
Middletown, N. Y.

TUBERCULOSIS SURVEY OF WILLARD STATE HOSPITAL*

A Preliminary Report

BY J. K. DEEGAN, M. D., F. BECK, M. D., J. E. CULP, M. D.

Early in 1938, it was noted by the staffs of the Willard State Hospital and the Biggs Memorial Hospital, Ithaca, N. Y., that seven cases of active tuberculosis of the lungs had been diagnosed during the preceding 18 months among the employees of the former hospital. These employees had all been diagnosed following the onset of respiratory symptoms and, consequently for the most part, were advanced cases. This number of cases among an employee group of approximately 750 was considered very significant and indicative of a situation requiring investigation. It was found in addition, that another 12 of the 81 cases on the tuberculosis register for Seneca County were working or had worked at Willard State Hospital and that some of these tuberculous employees had applied for compensation under the Workmen's Compensation Law. Accurate data concerning the incidence of tuberculosis in the patient population was totally lacking.

The problem resolved itself into two phases: (a) a tuberculosis survey of the patient population and the employees; and (b) an attempt to reduce the tuberculosis morbidity and mortality rate of these groups to the lowest possible level. At the initiation of the survey, there were approximately 50 beds for men and 50 for women patients located in separate, isolated buildings for the care of the tuberculous. A study of the patients so hospitalized revealed that approximately 50 per cent were not sufferers from tuberculosis of the lungs and should not have been classified as such. The lack of adequate diagnostic facilities, as well as the lack of personnel trained in tuberculosis work were probably the causes of this condition.

Survey of Employees

The survey of the employees and staff group included 794 individuals who had all had single posterior-anterior X-rays of the chest. Preliminary tuberculin testing was omitted because of the desire to simplify the mechanics of the survey and to obtain the most practical permanent record to be used in a study continuing over a period of years. This initial effort revealed eight new cases of clinically significant pulmonary tuberculosis in addition to two previously reported cases. Of the new cases, six were in the minimal stage, one in the moderately advanced stage and one in the far advanced stage. Laboratory studies revealed that five of the eight had

*Read at the quarterly conference at the Middletown State Homeopathic Hospital, September 21, 1940. For discussion, see conference minutes.

positive sputum; and that another whose sputum examinations were negative had an unstable lesion in serial X-rays. The two previously reported cases had had recent treatment for tuberculosis and were considered arrested.

An additional 16 employees were diagnosed as having definite reinfection type of pulmonary tuberculosis; but the Roentgenological appearances were those of apparently healed lesions. These employees are under close medical supervision and have frequent X-rays of the chest together with pertinent laboratory studies where indicated. There were also three employees whose chest X-rays revealed findings suspicious for tuberculosis, as well as another three who initially revealed undiagnosed pulmonary disease. The remainder of the employees presented no evidence of pulmonary disease, although 74 showed evidence of calcification of the lung parenchyma or hiler lymph nodes, presumably of tuberculosis etiology.

In the period September, 1939, to September, 1940, all the employees and staff had second X-rays of the chest; and in this checkup we discovered three new cases of pulmonary tuberculosis, all in the minimal stage. None of these employees had symptoms. At present, they are hospitalized and doing well. Another employee, one of the three suspects in the previous year, had developed pleurisy with effusion.

In summarizing the work among the employees, it should be pointed out that prior to the survey, cases were diagnosed because of symptoms and were naturally far advanced, requiring prolonged hospitalization and treatment. Of the cases found in the initial survey only one had symptoms; and he has subsequently died; the remainder were entirely asymptomatic and have done well under treatment. The fact that only four new cases were found on a recheck one year later—and that these were all minimal—points to a distinct economic saving and a definite reduction in the morbidity rate. The early trend of the control program among this employee group is distinctly encouraging and would seen to warrant its continuation.

Survey of Patient Population

At the onset of the survey our attention was directed to the problem of cost. Adequate fluoroscopic facilities were lacking, making the use of X-ray films necessary. Therefore, it was planned to do a preliminary "screening" by means of tuberculin testing and to X-ray the reactors only. A section of approximately 1,000 patients was tuberculin tested; and the reactor rate was found to be about 90 per cent. The high incidence of tuberculous infection thus revealed prompted us to X-ray the entire patient population. It was likewise felt that X-rays of known reactors and known non-reactors might be of great value in future epidemological investigations.

During the course of the survey all patients, except those known to be tuberculous, were subjected to intradermal tuberculin tests with 1.0 milligram of Old Tuberculin. The tuberculous received injections of 0.01 milligram, and if negative, received increasingly larger dosages intradermally up to 1.0 milligram of Old Tuberculin. The total number of patients tested was 3,317; and of these, 2,872, or 86.6 per cent, reacted. In analyzing our figures further, we noted that the number of reactors in the patients newly-admitted to the hospital was 354, or 69 per cent, of a total of 513, while the remainder of the population showed 2,518, or 89.8 per cent, reactors of a total of 2,804.

During the course of the survey, 3,407 patients were X-rayed. Patients whose X-rays showed evidence of tuberculosis were studied carefully in an attempt to evaluate the status of the lesion. In some cases, additional stereo-X-rays were taken; and in others, satisfactory sputum examinations were made. The problem of sputum examination in the psychotic patient is difficult; and judgment of the activity of the disease was made in many in many cases on changes in serial films or on evidence of cavity. It is our belief that 76, or 2.2 per cent of the patients have active tuberculosis of the lungs and that 157, or 4.6 per cent, have apparently arrested or arrested tuberculosis of the lungs. There is an additional group of 110 patients, or 3.2 per cent, who have apparently healed tuberculous lesions in the chest and an additional 351, or 10.3 per cent, who have calcification of the lungs or tracheo-bronchial lymph nodes, presumably post-tuberculous. It would therefore appear that a total of 20.3 per cent of all patients X-rayed revealed evidence of tuberculous disease or tuberculous infection. A review of the active cases of tuberculosis reveals that the peak incidence is in the age group of 35 to 44, following which there is a definite decline, with a subsequent rise in the age group of 75 and over.

Patients with active cases of tuberculosis of the lungs have been segregated in a building of modern construction where they can be closely observed and where adequate nursing techniques for the protection of the employees and other patients can be carried out. It is our hope that we can continue to recognize these active cases of tuberculosis early and can segregate them before infection of physically healthy patients or employees occurs.

Conclusion

1. The X-ray survey of the Willard State Hospital has revealed a high incidence of active tuberculosis among patients and employees.

2. Many cases of previously unrecognized active tuberculosis among patients and employees have been segregated.

3. The segregation and accurate evaluation of the clinical status of these tuberculous individuals permits the use of proper nursing techniques and modern methods of treatment.

4. All new patients should be promptly X-rayed and, should evidence of tuberculosis of the lungs be noted, they should be placed in the proper segregated group.

5. Periodic X-raying of the chest of psychotic patients is of definite value in the early recognition of cases of tuberculosis and the control of this problem.

6. Routine X-raying of the chests of employees in contact with tuberculous patients is definitely indicated.

Herman M. Biggs Memorial Hospital
Ithaca, N. Y.

MINUTES OF THE QUARTERLY CONFERENCE

SEPTEMBER 21, 1940

The Quarterly Conference of the State institution visitors and superintendents with the Commissioner of Mental Hygiene was held at the Middletown State Homeopathic Hospital, Middletown, N. Y., September 21, 1940, with Commissioner William J. Tiffany in the chair. There was a large attendance.

THE CHAIRMAN: Will the Conference please come to order?

It gives me great pleasure to introduce Miss Florence L. Ketchum, the President of the Board of Visitors of the Middletown State Homeopathic Hospital, who will give us welcome.

MISS KETCHUM extended a cordial welcome in behalf of Dr. Woodman, the staff, the personnel of the hospital and the Board of Visitors.

THE CHAIRMAN: The first paper on the program today is one by Dr. William Seaman Bainbridge of New York who for years has had an extensive experience in working with patients in the Manhattan State Hospital. I am sure we are all delighted to have Dr. Bainbridge speak on, "Somatic Factors in Mental and Nerve Conditions."

Dr. Bainbridge read his paper. (Pp. 51-67, with discussion.)

THE CHAIRMAN: As you know during the last two or three years the service has been devoting a great deal of attention to the subject of tuberculosis. Its importance is very great. We all know now that it is a compensable disease, i. e., an industrial disease; and the need for surveys in our institutions has been repeatedly mentioned.

We owe a great debt of gratitude to the staff of the Herman M. Biggs Hospital at Ithaca for their great interest and cooperation in studies in our institutions and especially in the Willard State Hospital.

Dr. Deegan, superintendent of the Herman M. Biggs Hospital at Ithaca, has been most cooperative. He and members of his staff have gone up there and surveyed both patients and employees in the institution, and I am very glad that we have been able to persuade Dr. Deegan to write a paper for presentation at this Conference. I hope it will detail the results of their study and offer more suggestions than have already been offered as to ways and means of doing the things which obviously need doing there and in other institutions.

Dr. Frederick Beck, the senior physician at the Herman M. Biggs Hospital will read the paper prepared by Dr. Deegan.

Dr. Beck read the paper. (Pp. 82-85.)

THE CHAIRMAN: Dr. Travis, do you care to say a word in the discussion of this excellent presentation?

DR. TRAVIS: Just what the future program will be we do not know, but we sincerely hope it can be continued. The purchase of films is the chief item of expense; and this expense is considerable. Funds had to be taken from the regular appropriations for medical and surgical supplies; consequently a sacrifice of many other essential materials was necessary.

Before the survey started, Willard State Hospital was using 14 dozen 14x17 films; and after it began about 66 dozen a quarter had to be bought. Dr. Deegan and myself have computed the cost of supplies for the purpose of keeping this work active, which we strongly feel should be done. The cost will be about $2,000 a year. Often we ran short of films, but the Biggs staff most generously drew upon its own supplies and loaned them to us.

Dr. Beck told you about the case of the one employee whose X-ray showed him to be far advanced. For years he had been working on the midnight to 8 a. m. shift. According to my information, he had not consulted any of the Willard staff but was being treated elsewhere for a gastric ulcer. Following the X-ray, further observation revealed that he also had tuberculosis of the kidneys and of the gastro-intestinal tract; he died in the course of a few months.

During the early period of the survey, when employees were being discovered with the disease, there was considerable agitation in the community; town meetings were held, and the topic of compensation was freely discussed. Nothing of this sort has occurred during the past year. All employees who have to take time out are told they have the privilege of applying for compensation. Most of them do this but no awards have been made; at least we have no information that they have. Employees upon recovery are reinstated. The chests of all applicants are X-rayed as part of the examination.

As the result of the survey, our method of caring for patients with tuberculosis has been more satisfactorily systematized. Before the survey, 90 patients were segregated in two old buildings; 50 per cent of these patients were not tuberculous. When the survey reached such a stage that we felt we had a comprehensive grasp on the situation the patients were segregated in a building of modern construction; we now have 230 patients so segregated. This structure was not primarily built for a tuberculosis pavilion; but, with a few alterations and the installation of new equipment, it answers the purpose quite effectively.

Our hospital is much indebted to Dr. Deegan and his staff for this very extensive work. He supplied doctors, technicians, clerks and equipment, including a portable X-ray apparatus. The members of the Biggs staff

came to Willard, week in and week out, and worked most assiduously devoting time which they could hardly spare. The survey has been of tremendous value to Willard. To keep the tuberculosis situation under control, the work must go on; and we hope our appropriations will permit it.

THE CHAIRMAN: Is there further discussion?

DR. BELLINGER: Because of the action of the State Insurance Fund in allowing compensation to those employees of the hospital who have developed pulmonary tuberculosis after having assisted in the care of tuberculous patients, we have made it a point at Brooklyn State Hospital to examine all new employees very carefully at the time of their employment. If any are found to be suffering from tuberculosis, we do not permit them to remain in the employ of the hospital.

One young woman, who applied for admission to our school of nursing during the month of August, was found to have active pulmonary tuberculosis. She was made conversant with her condition and given helpful advice relative to obtaining the necessary treatment without delay. She left the hospital at once to obtain treatment.

During the past two years, we have had two cases of pulmonary tuberculosis develop among the employees of the hospital. One case was that of a young woman employed as a medical and statistical clerk, who for some years had had no contact with patients. Although I offered to arrange for her admission to Ray Brook, she refused to go to that institution on the grounds that it was too far from her home. She received treatment in one of the local tuberculosis sanatoria where she died about three weeks ago. This case was promptly reported to the State Insurance Fund; but because of the fact that for some years she had had no contact with patients on the wards, her case was not held by them to be compensable.

The second case is that of a young woman who had been employed as an attendant on the wards for approximately eight years. At times, she assisted in the care of tuberculous patients in isolation prior to their transfer to Kings Park. At Brooklyn State Hospital, all patients found to be suffering from pulmonary tuberculosis are at once transferred to the pavilion especially constructed for patients of this type at the Kings Park State Hospital. This employee developed bilateral pulmonary tuberculosis and was admitted to Ray Brook where I understand she is making a good recovery. It was felt that she had had sufficient contact with tuberculous patients to warrant her case receiving favorable consideration. It is my understanding that she has been paid compensation since the onset of her disability.

Because of the danger of spreading the infection, and because of the matter of compensation, we are very careful to have all of our new em-

ployees and all others showing any symptoms of tuberculosis, examined for evidence of latent or active disease. We use our fluoroscope, cutting down the cost of X-ray films which are used only in those cases where signs of the disease are found to exist.

THE CHAIRMAN: Is there further discussion?

DR. SCHMITZ: I was very glad to hear Dr. Beck's paper because of its importance. I think that this work is something that should have been done long ago. At Middletown State Homeopathic Hospital, we have had the serious problem of the exposure of young employees to tuberculosis, and so we no longer place young people on the tuberculosis wards. This applies particularly to our young women; for we have had the unfortunate experience of having a number of cases of pulmonary tuberculosis develop in our pupil nurses after exposure in the tuberculosis pavilion. Tuberculosis is a disease of such varying characteristics and evolution that individuals who are hypersusceptible to it such as some of the young people we have had, have been seriously afflicted in a very short time. A survey, such as the one presented for discussion here today, should perhaps be done oftener than once in a year or a year and a half. Too long an interval would permit the development and spread of the disease and defeat the purpose of the surveys which is to find cases, segregate them, and render them noninfectious at the earliest possible moment. We have made surveys here at this hospital for a number of years. In the early surveys, ward physicians selected patients who were suspected of possible tuberculosis, either because of loss of weight or appetite, or other symptoms. Subsequently, we followed the practice of making X-ray examinations of all patients by services; and our findings parallel those of Drs. Deegan and Beck very closely. The matter of expense is of considerable importance especially in the making of large surveys where 14x17 films are used. The cost is further increased where the surveys are made at shorter intervals. Numerous attempts have been made recently to surmount this problem of cost by the use of smaller films. For this purpose, the 35 mm. standard size motion picture film has been used; and this has proved of value in a more or less coarse sifting of large masses of population to remove the more advanced cases from the communities and thus prevent them from acting as foci for the spread of disease. A short time ago more than half a million people had been so examined in Brazil. However, the 35 mm. film is very small, must be greatly magnified for study, and is likely to fail to reveal many of the early cases. It is just these early cases that should be found, for it is at this stage that the disease can be more promptly arrested. The General Electric X-ray Company has developed equipment which I think is superior in many respects to the 35 mm. method, as it utilizes a 4x5 film. While this

special equipment costs about $2,700, the saving in large surveys in film alone, would readily amount to this sum. Modern first classX-ray apparatus would, of course, need to be used with this special equipment. Surveys have shown that only one and a half per cent of the minimal or very early cases of tuberculosis have been missed by this means of examination. I think such equipment should be seriously considered by the department. A unit could be made to serve a number of institutions, and we could, thereby have means at hand for greatly reducing the morbidity and mortality from tuberculosis. Some such method must be employed if we are going to control the disease. In many cases, tuberculosis can be found radiographically a year or two years before symptoms appear. Occasionally, however, the onset after exposure is sudden and violent, resembling pneumonia, especially in young people who are hypersusceptible to the disease.

One of our male student nurses showed no evidence of the disease on repeated routine examinations. We make a practice of making such examinations before students are accepted for the training school and also before they go away for affiliation elsewhere. We again examine them when they return. This young man went away for affiliation. He was negative on leaving but developed acute pneumonic tuberculosis and later died. A study of our radiographs convinced the physicians at Bellevue that he had been, indeed, without any evidence of the disease on his arrival there. The case proved of such interest that they requested permission to retain our radiographs for teaching purposes. Fortunately, not many cases of tuberculosis develop with this extreme rapidity; but such cases do serve as examples to show the importance of finding and segregating those cases which act as foci for the spread of the disease—without permitting our young people who have not yet developed their immunity to tuberculosis—from coming in contact with them.

THE CHAIRMAN: Our time is limited but is there further discussion?

DR. BLAISDELL: We use the fluoroscope extensively in making our surveys. Some months ago, I received a circular descriptive of a fluoroscope and camera, which are integral parts of the same apparatus. That appealed to me because I could see that it might have certain advantages, particularly as to the cost of films and miniature negatives which may be filed in the patient's record. The cost of one of the negatives is insignificant. I wrote to the company to find the cost of the apparatus and learned that the concern is not selling it but is simply selling service at a price of 60 cents a patient, if engaged to make a survey of a large number of patients. One hospital, the Veterans' Hospital at Northport, has assembled one of these machines from standard apparatus and parts fabricated in the hospital shops.

I would like to ask Dr. Beck if dependable and accurate films can be made with the fluoroscope-camera apparatus.

DR. BECK: In regard to the use of cheaper X-ray methods than the 14 by 17 film, a study is being carried out in one of the State mental hospitals comparing the cost and efficiency of the 14x17 films, the 5x4 films and the 35 mm. film. The latter two employ the principle of photographing a fluoroscopic image and are cheaper than the 14x17 film. It is too early to discuss the comparative value of these methods, but it is hoped that some technique can be evolved to reduce the cost of X-ray surveys.

THE CHAIRMAN: Dr. Beck, do you care to say a word in closing?

DR. BECK: With relation to the use of the fluoroscope in diagnosing pulmonary tuberculosis, it is felt that the high percentage of error associated with this procedure, especially in the detection of the minimal cases, prevents accurate work. A diagnostic X-ray film taken previous to the hiring of an employee who later develops clinical tuberculosis is of greater value in claims brought under the Workman's Compensation Act. With respect to the use of fluoroscopy in the survey of psychotic patients it is apparently of little value in the bedridden cases; and it was found that the percentage of tuberculosis is definitely higher in this group.

THE CHAIRMAN: Our time is extremely limited and I feel that we cannot continue the discussion of this very valuable paper. I do want sincerely to thank Dr. Deegan and Dr. Beck for the very fine cooperation they have given us. They have already demonstrated the worth of this effort at the Willard State Hospital and I hope that when the remarks of Dr. Beck are published you will all consider them seriously, because the subject merits very intensive consideration. The next subject on our program is a paper entitled "Community and Family Care." The paper will be given by Dr. Percival H. Faivre who is senior assistant physician here.

Dr. Faivre read his paper. (Pp. 76-81.)

THE CHAIRMAN: I call on Dr. Gray to start the discussion of this paper.

DR. GRAY: Mr. Chairman and members of the conference: I shall not discuss this paper in detail, as the reader has covered his subject too well. Instead of going over the entire list of notes I have made, let me emphasize but two points. We do not agree with the essayist on the value of a community center. We believe it tends to set the patients, as a group, apart from the community. One of the features of family care is to socialize the patients better and make them a real part of the community.

Another point which I emphasized last year, and wish to emphasize again, is that in my humble opinion, the program of family care is of tremendous importance, especially from the educational standpoint. I think we have probably put over mental hygiene in the Gowanda State Hospital

district better by family care than in any other way, For years we have been discussing mental hygiene in our clinics, at lectures and luncheon talks, but nothing has caught the fancy of our people as family care; and we believe it went over with a bang.

THE CHAIRMAN: Dr. Storrs, will you continue the discussion?

DR. STORRS: Unlike Dr. Gray, I cannot discuss family care as far as psychotics are concerned but perhaps I can say a little in regard to the family care of mental defectives. I feel that the same conditions arise, we have to investigate the homes, etc., and practically everything in Dr. Faivre's paper I can second. It is a success. The largest number under family care from Letchworth Village last year was 105; then that number was reduced to 80, and it is back to 100 now. Of course, we have different classes of patients go out; and we do have difficulties. We started with the quiet, well behaved, clean, and older mentally-defective men and women. Family care with them has been very successful.

We have tried two other groups. The small child, as at Newark, was successfully placed. These children, particularly those of very high grade, have been getting along very well and have been practically accepted by the community, going to the schools and Sunday schools, and taking part in other activities of the community. We felt these children should never have been institutionalized in the first place; some of them had been problems in their own homes and, also, when placed alone in foster homes; but by placing them in groups of three or four in foster homes, they have had companions of their own type and have adjusted very well.

There was another group tried, those not capable of going out on so-called working parole but who could go out to family life as boarding-out patients and later—after they had been trained as helpers in the home—could be placed at practically no wages for a time and finally placed to receive wages.

What Dr. Faivre said about the up-State districts in New York State is very true. It was difficult at Wassaic to get family care started; and at Letchworth we found it very difficult. Near Letchworth, only a few homes were found in Rockland County, so we came up in Orange County; but there were not so many there as we hoped to find. Then, with the very kind assistance of the Middletown State Homeopathic Hospital, which let us in on its own territory in Delaware County, a large number of suitable homes were located. Family care has developed very much; and our social workers say there is practically no limit to the developments that could be made in sections like that. This seems to be true where people are struggling on back farms.

Dr. Faivre spoke about modern conveniences. Of course we are all delighted if the homes have modern conveniences, but some don't have them. One of the men in another state where family care has been tried told me that he did not care half so much about modern conveniences as he did about the character and the kind of home; if the patients were well cared for, he did not care if the houses were not so modern. Perhaps there is something to that.

I feel that distance is not such a serious objection. Many of our patients are in family care something like 140 miles from Letchworth. It is not difficult to visit them with a car; and usually visits are made every month. There is always something to do each month besides visitation; clothing can be delivered, and there may be a change of patients to be made.

I agree with Dr. Faivre and Dr. Gray that family care is a success; and we are going ahead with it just as fast as we can find the funds to support it. I again want to thank the Middletown State Homeopathic Hospital for helping Letchworth in expanding family care.

THE CHAIRMAN: Is there further discussion regarding this subject?

DR. FAIVRE: I have no further comments to make, but do wish to state at this time, that Middletown has enough homes that have been investigated and found acceptable to accommodate 50 more family care patients. Our only difficulty is having the patients to fill these vacancies.

THE CHAIRMAN: That is very interesting, Dr. Faivre.

DR. GRAY: May I say just one word more? Because of the interest in our district in the hospital, our patients and the family care system, we believe we could take care of more patients in western New York, if they were available in our own hospital, which they are not, or if they could be made available from down-State hospitals by transfer. This, of course, would be dependent upon our having an increase in personnel and funds for the several expenses.

DR. O'DONNELL: I had the idea we could send two or three hundred patients from the metropolitan hospitals up-State but since trying to place patients from Pilgrim State Hospital, we have been able to get more boarding homes on the Island than we have patients to put in them. We have found, too, that metropolitan patients want to go back to the city, they do not want to go into rural communities. Upon actual investigation, surprisingly few suitable patients are found.

THE CHAIRMAN read the following tribute to Mr. Farrington:

It is most appropriate for this Quarterly Conference to embrace this opportunity to pay tribute to Lewis M. Farrington whose regular attendance at conferences and frequent participation in their programs won the esteem and friendship of the members and whose devotion and loyalty to the serv-

ice, together with his broad general knowledge of innumerable administrative details and his engaging personality, made him of such unestimable value as secretary of the Department of Mental Hygiene for 19 years.

He died on August 30, 1940 in his home at North Chatham. A few close associates in the office and a few intimate friends knew of the heart handicap under which he had labored for several years. Despite this he was a marvel of efficiency and industry and no task was too exacting or burdensome for him to undertake if it appeared to be his duty. Furthermore, he gave generously his wise counsel and judgment to all of his associates in the Department, in the institutions, and especially to the commissioner, and to many from other departments who frequently sought his advice.

We are all fortunate to have had the friendship of Lewis M. Farrington and to have had the privilege of associating with him. He left a host of friends and a record of service to the State for us to emulate.

No one is better qualified to express an appreciation of him than our former commissioner who knew him better than any of us. Dr. Parsons has kindly consented to present to the conference an appreciation of Lewis M. Farrington.

Dr. Parsons read his tribute.

THE CHAIRMAN: We will now proceed as expeditiously as possible with the remainder of the program which includes reports of the committees. I will call on Dr. Woodman, as Chairman of the Committee on Nursing.

Dr. Woodman read the report.

REPORT OF COMMITTEE ON NURSING

The training school committee met at the State hospital at Middletown on September 20, 1940.

Dr. Pritchard in June had raised some very pertinent questions as to what would be the status of the training school pupils when all attendants are appointed from competitive lists. Accordingly a questionnaire was sent out to the superintendent of each hospital maintaining a training school to be sure just what is the present practice. It was learned that 10 of the hospitals admit prospective training school pupils as attendants between September and July and that seven do not do so. Those who follow this practice think well of it, as it gives interim employment to a promising candidate, avoids keeping unfilled attendants' items to be used by pupil nurses; it gives the candidate opportunity to find out if he or she really likes the work, and the hospitals using this system think it enables the school to appraise the candidate's potentialities better. Unless the Civil Service Department can suggest a better way, it is probable that after January 1, 1941, these candidates must come as pupils and not as attendants.

There may be some among civil service appointments as attendant who may be able to qualify and may wish to qualify as training school pupils, but obviously that source cannot be depended upon for recruits. Several of the hospitals make the suggestion that two training school pupils no longer be substituted for one attendant item but that the full number of attendant items be allowed and pupil nurse items in addition. All are agreed that the pupil nurse cannot be satisfactorily selected by any civil service test and most are of the opinion that they could not be so selected at all. Few arguments are advanced in this matter, it generally being referred to as obvious. Pupil nurses must have a nurse qalifying certificate before they can begin; and more factors, including personality, school records, background and health, must be considered than can ever be assembled at one time and place for examiners to endeavor to appraise. More prompt answers as to acceptance and rejection are demanded than the civil service examiners can be expected to supply. The future teachers of the applicants have both the experience and the facilities for doing this work. Pupils are interested primarily in an education and, secondarily if at all, in current employment and accordingly are interested in going to one school rather than another.

One suggestion was that the procedure of the Federal Civil Service Commission in selecting pupils for St. Elizabeths Hospital in Washington be followed. However, there is only one institution to consider there instead of 18, so that the government hospital there appears to be in substantially the same position as the individual training schools of this State under the present method of non-competitive selection.

Non-competitive civil service applications have been universally filed for each pupil nurse at the time of taking up the work. They may continue to be filed, if a non-competitive grade of training school pupil or some equivalent title, should be established. Perhaps training school pupils could be accepted by the chief examiner as competitive employees from the start on their school records and nurse qualifying certificate.

The questions bring out that the institutions have followed the practice indicated in General Order No. 54. When the pupil completed her three years of service she became an attendant with three years' time service to her credit and as such received $66 a month and was thus placed on a parity as to wages with others who began work at or about the same time but who lacked the qualifications or the inclination to pursue the formidable training school course for personal improvement. This seems nothing more than just; and several have expressed a wish to continue that practice. Others, if attendants are in the competitive class, see no other course than to con-

tinue the pupil as a non-competitive training school pupil until such time as the licensing examination is passed and a certificate of registration is presented to the management of the hospital.

Heretofore when this point was reached, and whenever the appropriations would permit, the young nurse received a slight advance in wages as a beginning reward for the studies undertaken and completed. Such a course would present no difficulties as long as the nurse position remained in the non-competitive class. The principal purpose of training nurses in a State hospital is to provide nurses with superior qualifications for our work and it would be unfortunate indeed if some civil service regulation operated to prevent this smooth transition. Perhaps the nurse positions will never be made competitive but when and if they are, suggestions are offered: One, that the State hospital nurses be given a high preferential rating. This, however, will not be enough, for nurses mature every year and, on account of lost time, and sometimes difficulty with the State Board examinations, not all are ready at the same time; and they must be promptly absorbed as they mature.

Another suggestion is that the Civil Service Commission place graduates of State hospital training schools at the completion of theri three years of study and work on a preferred list for appointment as attendant for the period between the completion of work and the passing of the State Board examinations. That would solve the matter if the Civil Service Department could see it that way. Another way of handling the matter would require a slight modification of General Order No. 54. It would be to pay the graduating class $70 a month as nurses when they complete their work in the fall and until such time as they obtain their registration, with a time limit of one year. Perhaps conference between the departments can straighten out these matters.

The first concrete difficulty likely to arise will be when the members of the class of 1940, who have time to make up, carry over into 1941, when they can no longer be paid as attendants and are not yet eligible for nurses' pay. The second concrete difficulty will arise, when, after January 1, 1941, it may be thought desirable to take part of next September's class into the service. That can probably be met by taking them at $27 a month instead of $54. The third difficulty might develop when, in order to accommodate these pupils on the estimate and payroll, it is necessary to change some attendant items to items for training school pupils.

Contracts offered by Bellevue and allied hospitals for State hospital pupils affiliating in New York City contain this year a clause concerning workmen's compensation. The matter was referred to the Department of Mental Hygiene, as the superintendents of the hospitals were not in posi-

tion to bind the State in any matter regarding workmen's compensation. A conference was held in which Mr. Clifton represented the Department of Mental Hygiene and there were representatives of the Department of Labor, State Insurance Fund, the Health Department and the Education Department relative to workmen's compensation in cases of injury to affiliate nurses, either in our hospitals or in general hospitals at the time of their affiliation. Representatives of the State Insurance Fund and also Mr. Holland of the Labor Department believed that the status quo as regards compensation should be continued. The State Insurance Fund representative brought forward the fact that conflicting decisions were being received from referees and judges in individual cases. In one case, the decision would be that the affiliate nurse was an employee of the hosptial where he or she was affiliated. In other cases, the decision was that the affiliate nurse was an employee of the hospital from which he or she was sent to take the affiliating course.

The conclusion of the conference was that the contracts should be signed and returned with the clause covering workmen's compensation eliminated, with the request that this matter be left to the individual determination of the referee or judge.

Miss Lena Kranz drew to the attention of the committee the fact that the principals of the training schools have held no meeting and have not met with the committee itself for several years past and that several had expressed to her a wish to have such a meeting. The committee believes that an occasional gathering of this kind is desirable.

A new training school has been established at the Pilgrim State Hospital. The school opened in September, 1940 with a junior class of 11 women.

The graduating class of 1940 consists of 236 and there are now 843 pupils in the training schools. More detailed statistics appear in the accompanying tables.

ROBERT WOODMAN, M. D., *Chairman.*

GRADUATES—1940

	Men	Women	Total
Binghamton	2	4	6
Brooklyn	5	14	19
Buffalo	1	8	9
Central Islip	5	15	20
Craig Colony	5	9	14
Creedmoor	1	5	6
Gowanda	6	9	15
Harlem Valley	1	5	6
Hudson River	4	16	20
Kings Park	2	14	16

	Men	Women	Total
Manhattan	7	18	25
Middletown	5	10	15
Rochester	2	11	13
Rockland	9	4	13
St. Lawrence	3	24	27
Utica	0	3	3
Willard	3	6	9
Total	61	175	236

CENSUS OF TRAINING SCHOOLS—SEPTEMBER, 1940

	Juniors			Intermediates			Seniors			Total		
	M.	W.	T.	M.	W.	T.	M.	W.	T.	M.	W.	T.
Binghamton	7	8	15	4	11	15	4	10	14	15	29	44
Brooklyn	20	30	50	17	24	41	10	15	25	47	69	116
Buffalo	2	6	8	..	7	7	5	5	10	7	18	25
Central Islip	8	22	30	11	19	30	11	15	26	30	56	86
Craig Colony	7	9	16	6	9	15	5	7	12	18	25	43
Creedmoor	2	11	13	3	11	14	4	5	9	9	27	36
Gowanda	5	8	13	8	5	13	4	5	9	17	18	35
Harlem Valley	5	8	13	..	..	..	5	7	12	10	15	25
Hudson River	4	12	16	4	9	13	8	10	18	16	31	47
Kings Park	3	8	11	5	10	15	5	8	13	13	26	39
Manhattan	..	..	..	..	..	..	5	15	20	5	15	20
Middletown	5	15	20	4	13	17	5	13	18	14	41	55
Pilgrim	..	11	11	..	..	..	..	..	..	..	11	11
Rochester	4	10	14	2	9	11	4	8	12	10	27	37
Rockland	18	19	37	12	7	19	9	13	22	39	39	78
St. Lawrence	6	19	25	5	17	22	8	21	29	19	57	76
Utica	..	12	12	..	15	15	..	14	14	..	41	41
Willard	7	7	14	4	3	7	3	5	8	14	15	29
Totals	103	215	318	85	169	254	95	176	271	283	560	843

THE CHAIRMAN: Does the Conference care to comment on the report of the Chairman of the Committee on Nursing? If not, what is the desire of the Conference?

It was moved and seconded that the report of the Committee on Nursing be adopted.

THE CHAIRMAN: Next is the report of the Committee on Uniforms of which Dr. Garvin is chairman, but Dr. Garvin is ill and Dr. Gray has consented to read his report.

DR. GRAY: To save time and to demonstrate visually what we wish to present, I am going to ask Dr. Young, acting first assistant physician of Binghamton State Hospital, who is here today representing Dr. Garvin, to hold up before you the garment under discussion, while I read the changes

in the specifications. We have one additional feature, a chevron of dark blue material, 2½ inches long by ¼ inch wide, to be attached to the left arm of the uniform, a little above the cuff; each chevron to designate five years of service in a New York State Hospital. The specifications, as read, represent the new uniform devised by and for the occupational therapy workers.

In addition, we present for your approval a smock to be worn by the librarian practically the same as the regular uniform, as given in the above specifications.

We present these to the Conference for approval and should like very much to have this approved today, so the workers can get into the new uniforms.

THE CHAIRMAN: What is the pleasure of the Conference regarding the report?

It was moved and seconded that the report of the Committee on Uniforms be adopted.

The requirements for uniforms as set forth in the following statement, including the amendments noted, were presented by the committee and accepted by the conference.

UNIFORM REQUIREMENTS

Chief occupational therapist (female): The material is to be of Craftsman (pre-shrunk) poplin. The color gray, and thread used for sewing to be vat dyed.

The waist to have shields of self material machine-stitched in the underarm of the sleeves for added reinforcement.

There is a slight puff at the top of the sleeves to give the uniform a more modish look, and at the same time allow for more freedom of the arm. Short sleeves are optional during summer weather.

The neckline to measure 20½ inches.

Waist and skirt are sewed on to a separate one-inch band of material for better fitting at waistline. The skirt has two panels in the front and three in the back. The two pockets on the skirt are of double material, with two rows of stitching. There is also to be a reinforcement of extra material underneath the skirt from waistline to bottoms of pockets. There are two snap fasteners in the placket of the skirt. The length of the skirt should be 13 inches from the floor, with an allowance of six inches for the hem.

There are to be four ocean pearl buttons, and buttonholes, on the waist, with a snap fastener at the top and bottom of the closing.

The cuffs of the sleeves to be 10 inches long and 2¾ inches wide. They are to have three buttons, with only one buttonhole for closing.

The two-inch adjustable belt is to have two buttons and buttonholes; it is to be secured at the waistline with snap fasteners, front and back.

A white front piece, 3½ inches wide at the top, fastened with snaps under the collar, and 2½ inches wide at the waist, to be fastened with snaps under the belt, is to be worn with the uniform. This plain white jabot, of permanent organdy, should have four buttonholes to button on the ocean pearl buttons on the waist of the uniform.

The collar is to be made of double white permanent organdy pointed in front and four inches wide all around. It is to be finished with a ¾-inch bias binding in which there are five buttonholes, one in center back, one on each side and one on each side of the front, to correspond with buttons on the neck of the uniform. The straight cuff is to be of the same material as the collar, double, three inches wide and finished with one buttonhole on each side.

For two period covering five years of State service, a chevron, 2½ inches long by ½-inch wide, of dull blue, is to be tacked on the left sleeve one inch above the cuff seam. The space between chevrons to be ¼-inch.

Gray stockings to match the uniform to be worn all the year round, with black shoes in winter and white shoes in summer. Shoes to be of sensible design, with rubber heels.

Occupational therapist (female): The material is to be of Craftsman (preshrunk) poplin. The color gray, and thread used for sewing to be vat-dyed.

The waist to have shields of self material, machine-stitched in the underarm of the sleeves for added reinforcement.

There is a slight puff at the top of the sleeves to give the uniform a more modish look, and at the same time allow for more freedom of the arm. Short sleeves are optional during summer weather.

The neckline to measure 20½ inches.

Waist and skirt are sewed on to a separate one-inch band of material for better fitting at waistline. Skirt has two panels in the front and three in the back. The two pockets on the skirt are of double material with two rows of stitching. There is also to be a reinforcement of extra material underneath the skirt from waistline to bottoms of pockets. There are two snap fasteners in the placket of the skirt. The length of the skirt should be 13 inches from the floor, with an allowance of six inches for the hem.

There are to be four ocean pearl buttons, and buttonholes, on the waist, with a snap fastener at the top and bottom of the closing.

The cuffs of the sleeves to be 10 inches long and 2¾ inches wide. They are to have three buttons, with only one buttonhole for closing.

The two-inch adjustable belt is to have two buttons and buttonholes. It is to be secured at the waistline with snap fasteners, front and back.

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For each period covering five years of State service, a chevron, 2½ inches long by ½-inch wide, of dull blue, is to be tacked on the left sleeve one inch above the cuff seam. The space between chevrons to be ¼-inch.

Gray stockings to match the uniform to be worn all the year round, with black shoes in winter and white shoes in summer. Shoes to be of sensible design, with rubber heels.

Special attendants and attendants (female): Uniform the same as that of the occupational therapist, except that the material is to be pre-shrunk Indianhead gray, and the collars and cuffs of pique. Chevrons showing years of service (each chevron to indicate five years) to be attached to left sleeve of uniform of Special Attendant Occupational Therapist.

*Occupational therapist (male)**: Gray flannel trousers, white shirt with collar of same material, and black bow tie. Gray flannel shirt with collar of same material, permitted for those in pre-industrial shop. The gray designated is to be of the same shade as the uniforms worn by women therapists. Gray coat or sweater to be worn in winter. Shoes may be black or white with gray hose. Male personnel engaged in shop activities may wear in addition a gray cotton smock of the same shade as the uniform worn by women therapists.

*Physical training instructor (female)**: Uniform to consist of gray poplin, same material and color as that used for the uniform of occupational therapists. It should consist of a tunic, blouse and bloomers. (If gray Indianhead is lighter in weight than poplin, it is agreeable that the bloomers be made of that material.)

Tunic is to be sleeveless, of suitable skirt length (17½ inches from floor) and width (suitability to be determined by the general size of person wearing the uniform). To be made with square yoke at front and back. Front yoke to have a "V" neck opening not more than five inches in depth. Body of tunic to have sufficient fullness, in box pleats or gathers, to start from yoke, in order to assure an "easy to wear" garment. To have six-inch

*Previously presented by chairman of uniform committee, passed by quarterly conferences, and so ordered.

hem. Armholes are to be cut of ample size to allow for free arm movement. The circular skirt may well be substituted for the pleated skirt used at present; if such a design is preferred, the waist section of the tunic may be gathered to the yoke instead of pleated.

Blouses worn under the sleeveless tunic to be of white cotton material, preferably light-weight poplin. Short or long sleeves to be optional. Step-in blouses are especially recommended to be worn with these sleeveless tunics as they prevent any disarrangement of blouses by physical exercises. Blouse to have "V" neck opening not more than five inches deep, finished with narrow pointed collar.

Suitable white gymnasium shoes to be worn with gray stockings.

Gray sweater, to match in color, may be worn when needed.

Standard uniform to be worn daily as well as at all hospital functions.

*Physical training instructor (male)**: Long gray flannel trousers and white cotton or gray flannel shirt, with collar to match, and black bow tie. White gymnasium shirt to be worn while engaged in actual exercises with patients, but not otherwise. Gray sweater to be worn when needed.

Black shoes and hose to be worn in winter, and white shoes in summer. Shoes to have low rubber heels.

Standard uniform to be worn daily as well as at all hospital functions.

Smocks for librarian in occupational therapy department: McCall Pattern No. 3516, Style A, may be used in making smock.

Material to be gray Indianhead, some shade as that worn by other occupational therapy personnel. White pique collars and cuffs, same as those used by special attendants and attendants in occupational therapy department, to be attached to smock. The sleeve to be long in winter and three-quarter length during hot weather, provided the librarian wishes a shorter sleeve.

The length of the smock should be three inches shorter than skirt of the dress being worn underneath the smock.

Belt of same material, 2½ inches wide, may be worn if desired, but is not recommended.

Gray stockings to match uniform to be worn with black shoes in winter and white shoes in summer. Shoes to be of sensible design with rubber heels.

THE CHAIRMAN: Next on the program is the report of the Committee on Home and Community Care by Dr. Woodmna, who is chairman of that committee.

Dr. Woodman read the report.

*Previously presented by chairman of uniform committee, passed by quarterly conferences, and so ordered.

Report of Committee on Home and Community Care

The Committee on Family Care met at the State hospital at Middletown on the evening of September 20, and submits the following report:

Members of the conference are familiar with the provision made for family care in the 1940-41 budget by segregating $350,000 from the funds of the several State hospitals and earmarking it for this purpose. We are able to report that the program is already well under way. In the State hospitals from July 1 to September 1 the number in family care was nearly doubled, rising from 209 to 412. The State schools, nevertheless, are still ahead of the State hospitals in their number. They have had a 57 per cent increase from July 1 to September 1 and have 437 patients in the community. Adding the two together, there were on September 1, 849 patients out, which is nearly up to the old peak; and it is possible that now, three weeks later, that peak has been equalled or surpassed.

A general growth of interest in family care was reported. Professional organizations have presented papers at their annual meetings upon this topic. Miss Crutcher found 18 inquiries on her desk after an absence of three weeks. Seven states are said to be doing family care work and inquiries have been received from popular national magazines for material suitable for their columns. No progress has been made yet on the formation of a colony as considered at the meeting of the Conference in September, 1939. The committee still thinks that separate appropriations are desirable for the purpose of family care and that they should be available to pay for board, and to meet travelling expenses and other expenses definitely chargeable to this department. It was reported that homes are being found up-State faster than patients can be found in the up-State hospitals to occupy them.

Robert Woodman, M. D., *Chairman.*

Comparative statistics of patients in family care for July 1, August 1, and September 1 are as follows. (The + sign indicates further known placements during September):

Hospitals

	July	August	September
Binghamton	11	11	19+
Brooklyn	2	2	2
Buffalo	..	..	..
Central Islip	1	15	42+
Creedmoor	..	..	..
Gowanda	2	2	2
Harlem Valley	23	54	66+

	July	August	September
Hudson River	..	5	22+
Kings Park	4	5	5
Manhattan	1	1	1
Marcy	12	29	31+
Middletown	90	97	95
Pilgrim	1	14	14
Rochester	9	9	14+
Rockland	..	..	..
St. Lawrence	4	18	33+
Utica	44	50	53+
Willard	5	5	13+
Psychiatric Institute	..	..	..
Syracuse Psychopathic	..	..	..
Totals	209	317	412

SCHOOLS

	July	August	September
Letchworth Village	82	82	94+
Newark	146	152	180+
Rome	..	..	..
Syracuse	..	..	..
Wassaic	51	61	63+
Total	279	295	437
Grand totals, hospitals and schools	488	612	849

THE CHAIRMAN: What is the pleasure of the Conference regarding this report?

It was moved and seconded that it be adopted.

THE CHAIRMAN: Next on the order of business is the report of the Committee on Statistics and Forms of which Dr. Pollock is chairman,—Dr. Pollock.

Dr. Pollock read the report.

REPORT OF COMMITTEE ON STATISTICS AND FORMS

Your Committee on Statistics and Forms has not had a meeting since the last conference.

A form for a clinical record of pharmacological shock treatment of patients was referred to the committee last spring by Dr. John R. Ross, superintendent of Harlem Valley State Hospital. The form was sent to each member of the committee and was considered by the medical staffs of sev-

eral State hospitals. As considerable objection was raised to the adoption of the form for general use throughout the hospital service, the commissioner thought it best to make the use of the form optional.

As no other matters requiring the attention of the committee were presented to your chairman, the committee was not called together.

HORATIO M. POLLOCK, Ph.D., *Chairman.*

THE CHAIRMAN: What is the pleasure of the Conference regarding this report?

It was moved and seconded that it be adopted.

Are there other committees to report? If not, I think Dr. Woodman at this time would like to make an announcement about luncheon.

Dr. Woodman made the luncheon announcement.

THE CHAIRMAN: Under new business, there is the matter of the revision of general orders. Dr. Pollock, will you present that?

DR. POLLOCK: In accordance with the provisions of Section 34, subdivision 12, of the Mental Hygiene Law, the following matters pertaining to general orders are referred to this conference:

1. Revision of General Order No. 24 relating to the reporting of communicable diseases. This order was modified to make the list of communicable diseases conform to the list specified by the State Department of Health.

2. In accordance with the provisions of Chapter 954 of the Laws of 1939, the Department issued General Order No. 56, relative to the reporting of cancer and other malignant tumors. The order provides that all State institutions connected with the department, except those located in New York City, are required to report to district health officers on the form provided by the State Department of Health for such purpose, every case of cancer or other malignant tumor among patients now in the institutions, or those found on the examination of patients admitted to such institutions.

Form 37-D. M. H. was modified so that the institutions could report to the department such cases of malignant disease along with the monthly report of cases of communicable diseases.

3. It is proposed to amend General Order No. 39, relative to fire protection in all licensed institutions by changing subdivisions 1 and 2 to read as follows:

Subdivision 1. There shall be a sufficient number of standpipes with connection for fire hose to insure the proper protection of each floor of buildings occupied by patients, provided, however, that no standpipes need be provided in one-story buildings of fire-proof construction and with exit facilities approved by the department.

Subdivision 2. All fire hose must be tested at least once in six months. Linen fire hose, after being tested or used, must be thoroughly cleansed and dried. Employees must be trained in the use of fire apparatus.

THE CHAIRMAN: What is the pleasure of the Conference regarding the new general order and the amendment to General Order No. 39?

DR. CHENEY: I am sorry that the provision for testing hose is retained because linen hose can be tested for its efficiency without having water put in it. It was my hope that the testing of the hose every six months would be eliminated; I think it is not necessary.

DR. MERRIMAN: I have been interested in this matter for many years and agree with Dr. Cheney that unlined hose ought not to be tested with water from the standpipe, nor used in fire drills, as wetting causes some deterioration of the fabric. For flushing valves on standpipes to which such hose is attached, a special piece of hose for tests should be used for such purpose. After a valve on a standpipe has been opened for any purpose, the regular hose at that valve should not be re-attached until it is ascertained, after a suitable interval, that there is no leakage of the valve and that it has seated satisfactorily. After re-attaching such hose, should the valve be found to leak, the hose should be immediately detached until it is thoroughly dry. Therefore, inspections of unlined hose should be visual ones, noting any dampness or abrasions. These remarks do not, of course, apply to rubber-lined hose, which is best kept by running water through it from time to time, as when rubber is in a static condition it may deteriorate, just as an unused automobile shoe may.

THE CHAIRMAN: Is there any other discussion?

DR. POLLOCK: The State law requires that hose used in State institutions be tested every three months but the law does not apply to private institutions.

THE CHAIRMAN: Of course you appreciate this General Order No. 39 applies to licensed institutions.

DR. CHENEY: Might I ask that the modification of General Order No. 39 with relation to fire hose testing be deferred until further inquiry can be made regarding the water testing of linen hose?

THE CHAIRMAN: We might act on the first paragraph. The suggestion has been made that an amendment be made to General Order No. 39 which now reads in part:

1. There shall be a sufficient number of standpipes with connections for fire hose to insure the proper protection of each floor of buildings occupied by patients.

2. All fire hose must be tested at least once in six months and the employees must be trained in the use of all fire apparatus.

THE CHAIRMAN: Is the Conference ready to act on the amendment of that first paragraph?

It was moved and seconded that the first paragraph of General Order No. 39 be amended.

THE CHAIRMAN: What is the pleasure of the Conference regarding Dr. Cheney's suggestion that the proposed amendment to paragraph 2 be tabled and given further study?

It was moved and seconded that it be tabled.

THE CHAIRMAN: At this time, the matter of the election of a representative to the officers of the State Hospital Retirement Board is in order. That has been done heretofore by this conference. What is the pleasure of the conference in regard to that?

DR. GRAY: I should like to place in nomination the name of Dr. John R. Ross, superintendent of Harlem Valley State Hospital. He has been very helpful and has done good service in the past. I should like to see him re-elected.

THE CHAIRMAN: You have heard the nomination of Dr. Ross to become officers' representative on the State Hospital Retirement Board. Are there any further nominations?

It was moved and seconded that the nominations be closed.

THE CHAIRMAN: What is the pleasure of the Conference regarding Dr. Ross' nomination?

It is moved and seconded that he be elected and it is so ordered.

Before adjournment for luncheon you will note on the bottom of the program that a meeting of the Board of Visitors Association will be held immediately after luncheon.

Motion for adjournment is in order.

The conference was adjourned.

REPORT OF THE COMMITTEE ON COMMUNITY AND FAMILY CARE*

The Committee on Community and Family Care held a meeting Friday, December 20, to consider ways and means to increase the number of patients in family care. The committee considers that its function is to keep in touch with the progress of this movement; to act as a stimulant, and in an advisory capacity to all institutions sending patients to homes in the community. It is the opinion of the committee that 3,000 to 5,000 patients must be placed in family care before this project can be considered a success. This would be the equivalent in bed space of a medium-sized hospital. At present, there are only 1,002 patients in family care; 601 from the hospitals and 401 from the schools. This number is considerably below the estimate that the institutions stated would be placed. Money set aside for this purpose is not being used to the fullest extent. It is needless to say that if the money is not used, difficulty will be encountered in the future when further appropriations are requested from the director of the budget and the Legislature.

It is the opinion of the comittee that by June 30, 1941 the hospitals should have at least 1,500 patients in family care and the schools 500. We offer the following recommendations and suggestions:

1. The movement has departmental approval; therefore, it is our opinion that all superintendents should particularly interest themselves in it, and order a diligent search throughout the hospitals they administer to find patients suitable for family care.

2. That a physician of the first assistant grade be assigned to take charge, and to see that patients are found.

3. That one social service worker devote her entire time to this project. We estimate that a social worker can supervise 75 patients on family care. Until such time as this number has been placed, there is sufficient work to do in finding and approving homes.

4. That patients suitable for family care should not be retained in the hospitals because they are good workers. There are many idle patients who could be developed, and it is a challenge to the institutions to do this.

5. That physicians make a particular drive among the senile and arteriosclerotic cases to find those that can be cared for in community homes. The number of admissions in these groups has increased greatly since the depression. Many patients of these types that are now sent to the hospital were formerly cared for in their own homes.

*Reported to the quarterly conference held at the New York State Psychiatric Institute and Hospital, December 21, 1941.

6. That caretakers be permitted to receive as many patients in their homes as they can properly care for. We recommend that not more than two be housed in one room and that each patient have a separate bed. Under certain conditions, where the floor space is sufficient, three may be permitted in one room but not more.

7. That sectional monthly meetings of the caretakers be held with the social worker and the physician, as may be indicated. Once a year, all the caretakers should be invited to the hospital for a general meeting for discussion of problems and instruction. A program of entertainment may be provided by the institution.

8. That a pamphlet of instruction for the caretakers be prepared. The committee will take this duty upon itself.

9. That a survey of all reimbursing patients be made and that where possible these patients be placed in family care with the relatives bearing the expense. At present, it is believed that there are at least 100 reimbursing patients in family care. (The reimbursing patients may be the answer for insufficient funds, as time goes on.)

10. We believe this movement to have great educational value in the community; and it is the experience of those who have worked with it that, after the public is informed and witnesses its operation, no great objection will be offered to the placing of patients.

Respectfully submitted,

JOHN R. ROSS, M. D.,
Chairman, Committee on Community and Family Care

LOOKING AHEAD IN MENTAL HYGIENE*

BY VICTOR HUGH VOGEL, M. D.
Assistant Chief, Division of Mental Hygiene
United States Public Health Service

It is a pleasure to be with a group doing so much in mental hygiene, especially after returning from a recent trip to a state which has no psychiatric clinics of any kind, only two psychiatrists in private practice and two crowded state institutions, with one doctor for every 500 patients. This, of course, permits no outpatient work. That state is now organizing a mental hygiene program; but it will take years to reach the point to which the New York program has developed; and the state should not stop there, because I suspect that even your program is less than ideal. The state in question wanted to economize on social workers in planning a program; I wonder if your community is doing that. There is some clinic work that only a social worker can do; and there is some that either a social worker or a psychiatrist can do. If a psychiatrist's time is occupied by tasks which a social worker should be doing and could be doing better, the clinic is not organized for optimum service.

With the exception of these remarks concerning the lack of social workers, anything else I may say which seems to refer to any local situation "living or dead, is entirely coincidental" as the movie prologues say.

It is not necessary to agree with psychoanalytical methods of treatment to quote with approval a statement made by Freud 22 years ago:

"But one day the conscience of society will awaken, and we shall realize that . . . man has the same claim to mental treatment that he now has to surgical aid. And we shall also come to see that the neuroses menace the health of the people no less than does tuberculosis, and that, like tuberculosis, the neuroses cannot be left to the ineffectual care of the individual himself. When that time comes, institutes and consultation centers will be established and staffed with . . . trained physicians, so that men who would otherwise give way to drink, women who might break down as a result of overwhelming deprivations, and children whose choice would be limited to delinquency or neurosis, may be strengthened . . . to resist such unhealthy tendencies and . . . become capable of social achievements. . . ."[1]

There are a number of reasons apparent why a determined attack on mental health problems has so long been deferred. Techniques for accomplishment in this field have been obscure; but they are becoming clearer.

*Address given September 24, 1940, at the annual meeting of the Oneida County Mental Hygiene Committee affiliated with the State Charities Aid Association, held jointly with the September meeting of the Utica Council of Social Agencies.

More specialists, i. e., psychiatrists, psychologists and social workers, are needed, but they will not appear in numbers until a demand for them is created. The very magnitude of this problem of assisting individuals to better social and community adjustment and the difficulty of deciding the most vulnerable points for a primary attack have deferred an organized concerted effort to reduce mental illness. Many of the factors which have delayed until recently an effective attack on syphilis apply to the field of mental disorders. There is the stigma which society has attached to both types of illness, with a consequent reluctance to admit the presence of disease in self or family, and with consequent disinclination to seek medical help, which, in the cases of both syphilis and mental disorder has been prolonged and expensive. There is ample evidence, however, of a changing public opinion and, as in the case of syphilis, it is believed that an improving attitude of the public will not only permit but demand an effective mental health program.

The president of the American Psychopathological Association[2] recently urged that the United States Government conduct a campaign for mental health similar to the campaign against syphilis. This opinion is one of an increasing number which recognize the necessity for a public health type of approach to the mental disorder problem. Dunham,[3] a Chicago authority, recently wrote that a primary condition for a mental hygiene program is that " . . . it should be a public-health program. . . . There is no need to enter into an extended discussion of this point for it is well recognized that the prevalence of mental disease is of such magnitude that no private enterprise could make much headway in dealing with it, and, besides, the problem traditionally belongs to the state. . . ." Scattered efforts of already overstaffed state hospitals may be very fine locally but will never result in an effective program upon a national scale. Not all states are as fortunate as New York in having a state division to see that mental hygiene clinics are not neglected in comparison with mental hospitals.

Strecker,[4] a Philadelphia authority, recently wrote: " . . . physical hygiene or public health and mental hygiene are inseparable. The boundary line between them is hypothetical and he who cannot see how they merge into each other and belong to each other is not sound in his reasoning. The ultimate objective of the doctrine of a sound body is the production of a better and more fruitful mind."

Health officers have been concerned with the conservation and prolongation of life. Remarkable results have been obtained; the average expectation of life at birth has risen from 38 years to 61 years since 1787, but should not health officers be concerned with the quality of life as well as the quantity of life? We deal, not with pigs or chickens, but with humans,

individuals like ourselves who have emotions, who have likes and dislikes, who experience happiness or sorrow and elation or depression. Not only do we experience these feelings, but they affect directly our capacity to take our places in the community as contented, healthy, law-abiding, self-respecting, self-supporting citizens. Mental hygiene is concerned with the abilities of people to adapt themselves to life; to live happier, more productive lives.

Should deaths by suicide concern the health officer less than deaths by typhoid or diphtheria? Is an emotionally dead person, maintained for 40 years in a mental institution less of a community problem than a person dead of smallpox? The productive labor of both is permanently lost to the community; but the psychotic individual is a ward of the state at perhaps $350 a year, and when he dies it still costs just as much to bury him as it did the smallpox victim. The mentally ill person maintained by his family outside the institution is not necessarily any lesser problem. Many the family whose normal relationships with happy emotional life for the children and happy marital accord for the parents is disrupted by the presence of a mentally ill person. Can we doubt that increased juvenile delinquency and rising divorce rates result? Is not a divorce more serious to the total well-being of a community than a case of diphtheria?

Chronic invalidism of neurotic individuals undoubtedly is a greater drain on the resources of your community than is typhoid. It is probable that the total incapacity from all types of mental disorder in a community is greater than the disability from all physical conditions combined. Are not such problems as tantrums, extreme shyness, troublesome aggressiveness and pathologic lying or stealing in children matters that concern human welfare; and are they not evidence of levels of health? They are forerunners of far more serious threats to total health than arise from dental caries, flat feet or poor posture, which give concern to public health officials.

Quoting Dr. Ira S. Wile:[5]

"It must be obvious that public health should concern itself with life—and all of it. This involves promoting the prevention of all things that tend to diminish the fullness of life, its intensity, its extent, or its duration. Every community harbors many individuals who are not defective nor psychotic, but who are unstable, inefficient, inadequate, antisocial, and they are all communal hazards. Many of them are merely victims of societal indifference or neglect. Some of them in sheer ignorance would in turn make society their victim. Mental hygiene would seek to restore such persons to normality, but, further, would attempt to lessen the likelihood that such unhealthful groups will develop. Hence, mental hygiene has value in

pointing out some of the factors and consequences of the struggle for well-being. It can indicate the way of avoidance, the presence of and the mode of release from fears and anxieties. It would have men fit to live. . . . It would have men fit to work. . . . It would have men fit to learn. . . . It would have men fit to love. . . ."

The capacity to live productively and happily is surely a concern of the same humanitarian organization which has been so long engaged in promoting public health in its usual conception. This quality of living is, I believe, the biggest problem yet remaining in the public health field. And the public health profession is responding. The chairman of the Division of Medical Sciences of the American Medical Association, in his recent address[6] to that body, said:

"The health officer is responsible also for the development of health programs in special fields such as cancer control, mental illnesses, industrial hygiene, and the identification and treatment of crippled children."

The appalling number of mental cases in institutions is well known. More than 600,000 persons in the United States are confined at the moment at a maintenance cost of over $200,000,000 a year. New cases are being admitted at the rate of about 120,000 a year. States are struggling in an effort to provide beds for this tide of admissions. It has been said[7] that, "We have been so busy trying to bail out the boat that we haven't had time to caulk the seams." There have been sincere efforts of various individuals and organizations to "caulk the seams." The activities of The National Committee for Mental Hygiene, organized in 1909, are notable. A number of mental hygiene clinics have been established with its assistance and a number independently, but no organization big enough and with sufficient resources has taken the responsibility for rendering an adequate service. Psychiatric clinics can rescue some from this stream of committed persons. If every admission to a state hospital costs the community $7,000, as has been estimated,[8] only three cases prevented or treated successfully short of institutionalization would be necessary to save the annual budget of a mental hygiene clinic. Furthermore, it has been estimated that 15 per cent of cases now in state mental institutions could be paroled if there were clinic facilities in the communities for supervision after release.[9]

Is it good business to continue paying $200,000,000 a year for custodial care of psychotic persons without a determined effort to reduce the hospital bill, both by research and clinics, for the application of such preventive and early treatment procedures as are already known? There is a great need for further research, but, as Dr. C. E. A. Winslow[10] says, "Nor is it feasible to forget the whole situation and wait till the progress of 50 years has automatically clarified it. The men and women who are living today are

fighting their daily battles. They need, they demand, they deserve, the best aid which our present knowledge of the danger and our present weapons of defense permit." New York has not waited to make a start, but 15 states are entirely without mental hygiene or psychiatric clinics, and there are large areas in other of these United States in which no such facilities are available, not even private practising psychiatrists; no one to whom a patient facing mental breakdown or emotional crisis can go for aid; no one to treat early cases of neuroses before they become fixed in the rut of chronic invalidism; no one to recognize early psychoses when treatment is most apt to restore them to society, and no one to whom the general practitioner can refer a case for psychiatric consultation.

Mention must be made of the still larger group of persons who stand in little danger of becoming psychotic or being committed. I refer to many of the behavior problems in children, the neuroses with their prolonged disabilities, and especially to the problems in psychosomatic medicine. It has been estimated that 35 per cent to 40 per cent of all persons carrying complaints of organ dysfunctions to physicians are suffering primarily from an unrecognized emotional or personality disturbance. One author puts the figure as high as 85 per cent.[11] Some of these patients who might be restored as productive members of society become—in the absence of adequate appreciation of their problems—the subjects of medical mismanagement. This frequently results only in strengthening these patients' convictions regarding the physical source of their disability. It is disturbing to consider that a needless operation may be performed for lack of psychiatric knowledge or advice. We need more and better psychiatry taught in our medical schools, as well as more specialists in psychiatry; but we are slowly improving.

Referring to results to be expected from the child guidance activities of mental hygiene clinics, it has been estimated that in 25 per cent of their cases the presenting problem is completely eliminated, and in an additional 50 per cent there is great improvement. In one state in 1938, it is estimated that one child guidance clinic, costing $30,000, saved the state $140,000, by the children saved from correctional institutions. This does not include those intangible, but more important gains in the way of improved family relationships and increased happiness. Osler[12] once said, "There are people in life and there are many of them whom you will have to help as long as they live. They will never be able to stand alone." It is this type of person who may be kept on the job, self-supporting and relatively happy by mental hygiene guidance. Is it not more important to assist in a lifelong productive adjustment of an individual than merely to prolong his life without regard to the type of living experienced? "For

each individual who is actually deranged mentally there are at least 10 who are blindly groping in that dread 'no man's land' between reality and unreality, or sanity and insanity.'"[13]

The United States Public Health Service proposes two primary steps in organizing a more effective mental hygiene program:

1. The establishment of a division or department of mental hygiene or mental health, headed by a full-time psychiatrist of special qualifications, in each state. This department should be either part of, or work in close cooperation with, the state health department, except in states where a well-established mental hygiene program exists independently or in some other department of the state government.

2. Organization of a mental hygiene or psychiatric clinic in every community, county or city which now has a health department. This will necessarily follow organization of the state office just mentioned.

Cities of 100,000 or more must be encouraged and aided in the formation of full-time mental hygiene units. Most of the communities to be served, however, are smaller, and the states should accept the responsibility for furnishing them with centralized service in the form of traveling clinical units. Training programs for public health officers and nurses in the field, as well as representatives of social agencies, must be given as a basis for satisfactory community service. State programs must of course be individualized, taking into account such factors as population distribution and the utilization and organization of private or other psychiatric facilities which already exist. One very important point in the organization of psychiatric clinic service should be mentioned. I refer to the necessity of preventing overloaded clinics. These result in the emphasis being placed on examination and diagnosis rather than treatment. A mental hygiene clinic does not deserve the name unless it is solving problems presented to it. The clinic mentioned, which saved $140,000 in one year, arbitrarily limits its registrations to the number that can be treated. Obviously, a better solution than limiting registrations is to increase the staff until all applicants can receive adequate and proper service. If mental hygiene clinics are profitable, then the more money spent for them the better. For the same reason, part-time or traveling clinics should be organized so that the communities concerned are covered at least once a week, because many patients must be seen that often if the problems are to be solved or some individuals saved from institutions.

I have not mentioned research, except in passing when I said that the establishment of mental hygiene clinics should not be delayed until all problems have been solved. Faris and Dunham[14] have recently reported interesting work on the relationship of social and economic community con-

ditions to the development of various types of mental disorder. A five-year study in Kentucky, as yet unpublished, has recently been completed on the correlation of 75 social and economic factors with the development of mental disorders. Franklin County, Tennessee, is completing a five-year study on the incidence of mental disease. This work will attempt to throw light on the amount of the various types of mental disorders to be expected in a population. There is also need for determining how much mental hygiene or psychiatric clinical service should be supplied for a community of a given size. What is the saturation point for profitable service? Present standards are tentative only. Perhaps Oneida County can extend its program to the point where no one who could profit by psychiatric attention would be without it. If Oneida County does this, it will serve the nation in answering the important question of what standards of psychiatric or mental hygiene care should be provided for fully adequate service. The community that first answers this problem will, of course, be serving itself even more. The United States Public Health Service is now planning to operate a national institute for research in nervous and mental diseases. This will conduct research into the unsolved problems relating to psychiatry and neurology and will correlate research activities of other individuals and institutions throughout the country.

Mental hospitals have fairly satisfactory standards of psychiatric care. It has been my recent pleasure to assist Dr. Samuel W. Hamilton, previously of the Utica State Hospital staff, in hospital survey work, which he has been doing for 25 years. Dr. Hamilton is now associated with the United States Public Health Service; and the survey staff is to be augmented by a psychologist with considerable experience in the psychiatric statistical field and by a psychiatrically-trained nurse. Deplorable conditions still exist in some state hospitals. I recently had the unpleasant experience of visiting an overcrowded institution where the patients were fed almost exclusively on boiled foods, costing 10½ cents a day for each person. There was neither an occupational director nor a recreational director in this 4,200-bed institution. There were no moving picture shows, no books, very few magazines and virtually no playing cards or games. Bathroom facilities were deplorable. In some wards, there was no place for patients to wash their hands; and in one or two the only bathing facilities were a garden hose and a floor drain. Visits to the wards revealed row after row of idle, dilapidated men and women, sitting hours without end in poorly ventilated basement quarters, many in mechanical restraint on their wooden benches. Many physically fit patients had not been out of doors for years.

The title of this address invites me to picture a more or less ideal mental hygiene program in the light of our present knowledge.

Continued efforts must be made to improve the care of mentally ill in the hospitals to a point more comparable with surgical and medical hospitals. Emphasis must be placed on intensive early care because 50 per cent of the cases which improve sufficiently to be discharged do so in the first six months of hospitalization. I see a typical mental hygiene unit consisting of one psychiatrist, one psychologist, two psychiatric social workers and a clerk, giving psychiatric outpatient service on a full-time basis to cities of 100,000 or over, and part-time service to smaller communities in proportion to their population. These clinics will be closely identified with other types of preventive public health work, with the clinics usually held in health centers. The clinics will cooperate closely with the welfare and educational departments of the state, as well as with the courts, churches and relief agencies. They will properly stress child guidance work, but will offer adult psychiatric service also with care of prepsychotics and neurotics. They will furnish consultation service to local physicians, who are becoming increasingly aware of the need for psychiatric attention in the every-day practice of medicine.

On the premise that prevention and early care are inseparable and that the whole is a public health problem, the establishment of psychiatric clinics in every community which has other types of public health service is essential.

Picture this psychiatric unit as the center of all mental hygiene activities in the community, working in cooperation with various social, relief, and public health agencies. The formation of active local mental hygiene committees or societies should be an activity of this clinic. It should likewise be a clearing house for admissions to state institutions, and the center for parole supervision of patients discharged from state institutions. The formation of discharged patients into social groups or organizations, not only for the mental benefit of the ex-patient but as a matter of community education, has been mentioned as an extremely fertile mental hygiene field.

Education and promotional work in the mental hygiene field organized by the community clinic—which can accompany the "preaching" by actual demonstration in its daily clinical work—is the most effective type of educational work.

More humane admission laws are necessary in a number of states, with provision for precommitment care in psychiatric wards by physicians rather than incarceration in jails or at least pre-commitment supervision by health

officers. Transportation of committed patients to institutions by other than law enforcement officers is needed in many places; the best arrangement is to have members of hospital staffs call for patients. Provision for temporary and voluntary treatment—in uniform laws by the various states covering these matters—is also needed.

I picture the Federal government rôle as one of helping the states, both with advice on organization and with funds, and the states offering similar service on a smaller scale to their cities and counties. I see the Federal government playing an important rôle in actual research, correlation of research efforts, and interpreting to the community units for practical application all research in this field.

In conclusion, consider now a community with adequate service along the lines mentioned, utilizing research developments as they appear; a community in which educational efforts have broken down prejudices against psychiatry and have broken down unwholesome attitudes which regard mental disease as evidence of constitutional stigmata with consequent reluctance to seek treatment; a community in which delinquency has fallen, unemployability has decreased, divorce and suicide rates decreased; a people living well and well satisfied with its way of living.

It is timely to mention the importance of mental hygiene in the present world crisis, both to assist civilians in facing the present and future with courage and to utilize psychiatry in the better selection of military recruits. Mental hygiene principles can be used to obtain maximum efficiency with minimum disability from the armed forces. Evidence exists that in the last war, military units in which psychiatrists prevailed on officers to adopt less rigidly formal relationships with their men, and to develop a more friendly personal understanding of the problems of the enlisted men, showed a decided decrease in the incidence of "shell shock" and other forms of psychoneuroses. We may speculate, that just as the present venereal disease program really had its beginning in the preventive efforts during the last war, that an effective, determined drive for mental hygiene may develop as a result of the present world conflict.

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CHILD GUIDANCE CLINIC DAY

Child guidance clinic day, so designated by the Oneida County Mental Hygiene Committee, was observed in Hutchings Hall, Utica State Hospital, on Tuesday, September 24, 1940. It was the thirteenth annual meeting of the committee, and it was held jointly with the Utica Council of Social Agencies.

The Oneida County Mental Hygiene Committee of New York State Committee on Mental Hygiene, of the State Charities Aid Association, is composed of a group of public spirited citizens, who are organized to stimulate, and further interest in, the mental hygiene movement by keeping the community in touch with the latest developments in the care and treatment of mental illness, with special emphasis on preventive measures.

Dr. Milledge L. Bonham, Jr., head of the department of history, Hamilton College, had served as chairman since the committee's formation, with the exception of one year when he was on sabbatical leave. He was re-elected at the annual meeting.* Others elected to the executive group were: Vice chairmen, Robert Sloan, M. D., and Miss Mary Evans; treasurer, Miss Ida M. Henry; secretaries, Misses Eva M. Schied and Inez Stebbins; Hon. Curtis F. Alliaume; R. H. Hutchings, M. D.; W. E. Merriman, M. D.; W. W. Wright, M. D.

The statistical report (pp. 120, 121, 123) of the community mental hygiene clinic facilities of the county for the past two years was printed on the programs—nearly 5,000 of which were distributed.

*Dr. Bonham died on January 22, 1941. Biographical notes on his career appear in the News and Comment section of this issue of the SUPPLEMENT.

STATISTICAL REPORT

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE CLINIC SERVICE GIVEN IN ONEIDA COUNTY FOR THE PERIOD FROM JULY 1, 1938 TO JUNE 30, 1940

Personnel Supplied by

THE CENTRAL OFFICE IN ALBANY, UTICA AND MARCY STATE HOSPITALS

Child Guidance Clinics

	Male	Female	Total
For the year ending June 30, 1939:			
Utica:			
First visits	**38**	**38**	**76**
Return visits	**8**	**3**	**11**
Total	**46**	**41**	**87**

	Male	Female	Total
Rome:			
First visits	26	7	33
Return visits	6	4	10
Total	32	11	43
Occasional clinics held in Sherrill, Remsen, Holland Patent, New Hartford, Chadwicks:			
Total	19	10	29
Grand total	97	62	159
For the year ending June 30, 1940:			
Utica:			
First visits	41	43	84
Return visits	15	5	20
Total	56	48	104
Rome:			
First visits	38	14	52
Return visits	9	2	11
Total	47	16	63
Occasional clinics held in Sauquoit, Camden and Whitesboro:			
Total	22	9	31
Grand total	125	73	198

Mental Hygiene Clinics

Utica Dispensary, Weekly Sessions

	Male	Female	Total
For the year ending June 30, 1939:			
Children:			
First visits	17	9	26
Return visits	39	32	71
Total	56	41	97
Adults:			
First visits, community patients	43	57	100
Return visits, community patients	264	324	588
Total community patients	307	381	688
Discharged hospital and paroled patients:			
First visits	9	6	15
Return visits	41	78	119
Total	50	84	134
Grand total	413	506	919

	Male	Female	Total
For the year ending June 30, 1940, weekly sessions:			
Children:			
First visits	10	6	16
Return visits	37	28	65
Total	47	34	81
Adults:			
First visits, community patients	54	77	131
Return visits, community patients	267	382	649
Total community patients	321	459	780
Visits by discharged hospital or paroled patients:			
First visits	1	4	5
Return visits	94	115	209
Total	95	119	214
Grand total	463	612	1,075

Mental Hygiene Clinics

Rome Health Center, Monthly Sessions

Adults:			
For the year ending June 30, 1939:			
First visits, community patients	15	21	36
Return visits, community patients	32	81	113
Total community patients	47	102	149
Discharged hospital and paroled patients:			
First visits	3	0	3
Return visits	62	38	100
Total	65	38	103
Grand total	112	140	252
For the year ending June 30, 1940:			
First visits, community patients	9	14	23
Return visits, community patients	18	45	63
Total community patients	27	59	86
Discharged hospital and paroled patients:			
First visits	2	2	4
Return visits	58	30	88
Total	60	32	92
Grand total	87	91	178

Morning Session

Sixty persons showed their vital interest in the community responsibility for child guidance clinics, which was the phase of the problem considered in the morning, at the meeting presided over by Miss Mary Evans, vice chairman of the committee. Donald W. Cohen, M. D., chief child guidance psychiatrist of the State Department of Mental Hygiene, gave a comprehensive outline of the policy of the department and led in the discussion.

Afternoon Session

Robert Sloan, M. D., vice chairman of the committee, presided at the afternoon meeting, which was attended by 35 physicians. Some of the psychiatric problems arising in the practice of medicine were discussed by Victor H. Vogel, M. D., who also addressed the evening meeting.

Evening Session

The evening meeting which was attended by 250 persons was preceded by a dinner, during which Mrs. R. D. Helmer played organ music for the 120 diners. Dr. Bonham presided at, and conducted the meeting. The program follows:

Dr. Bonham: Ladies and Gentlemen: Some of you were privileged to attend the conference this morning on the community's responsibility for child guidance clinics. A few of you were fortunate enough to be present this afternoon at the session on psychiatric problems in the practice of medicine. This evening we are to have a round table on the functioning in the county of child guidance clinics, in which each speaker will present very briefly one phase of the subject. After the principal address, an opportunity will be given for question and discussion from the floor.

It is now our rare good fortune to hear from experts how a child guidance clinic operates. Unfortunately, two of our scheduled speakers cannot be with us. Dr. Donald W. Cohen, chief child guidance psychiatrist of the State Mental Hygiene Department, has been summoned back to Albany since the morning session. Miss Lena A. Plante, chief social worker of the Marcy State Hospital, is ill.

Our first speaker needs no introduction. Not only is she the guiding spirit of the Mental Hygiene Committee, but she is the chief social worker at the Utica State Hospital. Miss Eva M. Schied, our efficient secretary, will give "The History of the Clinic Movement in Oneida County."

MISS SCHIED: The Utica Mental Hygiene Clinic began to function in 1919, and that in Rome in 1937, with occasional clinics as needed. These were established at the request of the community, in line with the policy followed by the Department of Mental Hygiene throughout the rest of the State.

It is interesting to note that the Utica clinic was started by the late Dr. Joseph Clarke, local district officer for the New York State Department of Health and a man who had had psychiatric training. He conducted the first two sessions and then arranged with Dr. R. H. Hutchings to have it taken over by the staff of the Utica State Hospital. The clinics were held weekly at the old dispensary on Mary Street and soon demonstrated their worth. I remember on one occasion that 20 children with accompanying parents and social workers presented themselves in one day. It was realized that treatment under such circumstances would, of necessity, be too superficial to be of value.

Dr. Hutchings asked for help from the State Commission for Mental Defectives, as it was called at that time. (The title was changed in 1928 to the Department of Prevention, as its scope of activities increased.) Dr. Earl Fuller from the Rome State School, and a psychologist from the Albany office were assigned to this work for one day a month—their attention to be focused on the children. Thus, the first definite child guidance clinic was held in Utica in 1921.

At first, sessions were held jointly with the adult mental hygiene clinic, which continued its weekly sessions and still conducts them under the leadership of Dr. W. E. Merriman. It soon became necessary to find other quarters, because of limited space in the Mary Street building. The child guidance division was moved to the Grand Army rooms on the first floor of the Court House until the splendid new dispensary was opened in 1929, when the two clinics were reunited. The children wait in a screened-in alcove.

The social service departments of Utica and Marcy State Hospitals have the responsibility of the administrative work of the clinics, which consists of making appointments and arranging for the preparation of adequate histories; but these departments can take little or no responsibility for follow-up of child guidance clinic cases.

In Utica, the social service department also has the full responsibility of the weekly mental hygiene clinic and must use judgment in selecting children with prepsychotic tendencies or neurological disorders for treatment at the weekly clinic. Parenthetically, let me say these children must

have had a psychological test given by the school psychologist before being accepted for treatment. Followup work in this clinic is carried on through the social service conference method with other agencies.

In your view of the statistical report, we ask you, please to visualize each figure as an individual whose problem must be understood before treatment is outlined—hence, the importance and necessity of adequate histories.

It may be interesting in this connection to state that appointments must be made well in advance of the clinic. Appointments have already been scheduled for the October child guidance clinic day and that of November is almost filled.

The Utica clinic has been fortunate in having been served by unusually able physicians, in the child guidance clinic by: Dr. Earl Fuller, now director of the Northern New Jersey Mental Hygiene Clinics; Dr. M. C. Montgomery, first assistant physician of the Rome State School; and Dr Marion Collins, who will speak for herself tonight. The adult mental hygiene clinic has been served by: Dr. W. W. Wright, superintendent of the Marcy State Hospital, under whose direction the clinic service has developed in the territory served by that hospital; Dr. Clarence Russell, pathologist, and Dr. R. D. Helmer, first assistant physician of this hospital; Dr. Clarence O. Cheney, medical director of the New York Hospital, Westchester division; Dr. N. J. T. Bigelow, clinical director of the Pilgrim State Hospital, the largest in the State; and now Dr. O. J. McKendree, who will also speak for himself.

The Utica clinic also serves as a training center for students and volunteers in social work. Our ex-students are functioning in 12 states and many in the state of matrimony.

DR. BONHAM: Now that we know how the clinics came about, we are ready to learn just what a child guidance clinic is. Fortunate are we in having it explained to us by the acting clinical director of this hospital, Dr. Oswald J. McKendree, who will answer the question, "What Is a Child Guidance Clinic?"

DR. MCKENDREE: This question is somewhat difficult to answer adequately in the time alloted; and for a good definition one might refer to that of Stevenson and Smith, who describe it as an organization which utilizes the various resources of the community for the purpose of aiding the child who is in distress as a result of difficulties which he is having with his environment and inner self, or whose development is being thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behavior and inability to cope with social and scholastic expectations. Not only is the clinic a source of relief to these children; but it is also a definite aid to the bewildered, anxious parents of such children.

The parents, heretofore, in many instances, have handled their children by means of what might be called the common sense method; but the particular problems at hand require reeducation on their part, changes of their attitude toward the children and the administration of new facts of a scientific character to parents so that they can discharge their responsibilities properly.

The child guidance clinic attempts to study human behavior scientifically in its pathological aspects. Those concerned in it have their attention focused on what is called the mental hygiene approach to problems of behavior. An attempt is made to study behavior objectively, without prejudice, in the hope of discovering the cause of such problems. Those who conduct the clinic attempt to solve the problem at hand by eradicating the cause rather than by the employment of a show of authority.

The clinic, which to a large degree is dependent upon lay and professional groups for proper functioning, seeks to interest other agencies in the prevention of behavior and personality disorders, and in promising methods of dealing with them when they occur. It also tries to reveal to the community the psychological needs of groups of children.

DR. BONHAM: We are next privileged to hear how the clinic tests a child's capacity. It is our good fortune that we have it explained by the psychologist from the State Department of Mental Hygiene, who serves the clinics in this county, Mrs. Norma Russell Terry.

MRS. TERRY: In child guidance clinics, it is necessary to evaluate the child's specific capacities for learning. The psychologist chooses, from the ordinary tests, those which seem most appropriate. They provide a general picture of the child's development that can be used as a satisfactory starting point for further study, together with the family and personal history, and more detailed psychiatric and physical examination. In a traveling clinic, it is impossible to have a complete laboratory of tests, but we are able to carry the essential ones in hand luggage.

Practically all tests rate the child according to mental age and have been standardized accordingly. For instance, a child who is 10 years old and has a normal intelligence, has a mental age of 10 years. But suppose that a 10-year-old child is found to have a mental age of eight years. Obviously, he has not normal intelligence. The intelligence quotient, or I. Q., was devised as an easy, convenient method by which to compare the abilities of different children, or the ability of the same child at different ages. The I. Q. is determined by dividing the mental age by the chronological age. Thus, the 10-year-old child with 10-year mental age, has an I. Q. of 100. The 10-year-old with a mental age of eight, has an I. Q. of 80. A 10-year-

old with a mental age of 12, has an I. Q. of 120. The mental age tells what the child is able to do at present, and the I. Q. or intelligence quotient really gives a prognosis of what may be expected for the future.

Two children with the same chronological age and the same mental age may be quite different. One might be well adapted to school work and the other poorly adapted because of his emotional makeup, special disabilities and other factors. Just to give out an I. Q. without interpretation is often misleading and unjust, especially with the preschool child. A preschool child who tests a little below his chronological age should have the benefit of the doubt; and all environmental factors should be taken into consideration. This is most important in planning for children for adoption. Our tests begin at the six-month level, but we realize that they can give only an approximation. However, a six-month baby that tests up to the age on the Gessell and Kuhlmann scales nearly always retains his normal rating. Children of preschool and kindergarten age who have had a very limited environment and test below normal frequently show considerable improvement when placed in a stimulating foster home. Where emotional and extraneous factors throw doubt on the validity of a single examination, we do not hesitate to retest a child several times at six-month intervals.

Mental tests are of great value in selecting children for special help in school, those handicapped by reading disabilities, speech difficulties, etc. A child who has difficulty in keeping up with his classes gets along much better, and with better personality adjustment, in smaller classes, where academic work is given at a slower rate than in the regular grades, and, where there is emphasis on manual work. When a superior child is referred to a child guidance clinic, a mental test readily discloses his above average ability. In the past, about the only procedure in such a case, was promotion to a higher grade, with children whose play and social interests were more advanced; but, at present, there is the possibility of an enriched curriculum in a grade suited to his chronological age. With older children, tests aid a great deal in the field of vocational guidance. The psychological study is thus an appraisal of the child's mental assets and liabilities, his educational capacities, his special abilities and disabilities.

DR. BONHAM: Our next speaker will show that the child guidance clinic is a community affair—not merely the duty of the clinical directors. This phase of the topic will be presented by Dr. Frank R. Henne of the Marcy State Hospital.

DR. HENNE: It is my wish to present to you briefly the case of a 15-year-old boy. My purpose is to demonstrate that child guidance is not simply the function of a mental hygiene clinic, but rather requires the en-

lightened understanding and cooperation of the family, the school, the general medical practitioner, the court and various social agencies.

A church welfare society referred this patient to our clinic because he had been involved with three other boys in stealing and because he had been unhappy, poorly adjusted and retarded in school.

The youngest of six children, our patient was the only one who failed to progress satisfactorily in school. The others were ambitious and proud of their achievements. The boy was acutely aware of his inadequacies, which the family did not neglect to point out to him. On occasions, members were indiscrete to the extent of telling him that he was "dumb."

At the clinic, the patient was found to have a mental age of 11 years and an intelligence quotient of 70 which would classify him as a high grade moron. In addition, it was discovered that he was suffering from a glandular disorder such that physically he evidenced certain feminine characteristics.

It was readily seen that he was unhappy. He disliked school and was discouraged. His family was insisting that he continue with his school work, telling him if he did not go to school he would not know anything. Since he had been in difficulties with the law, his liberties had been further restricted. He wanted to live his own life with some freedom of action instead of having his activities completely directed by others. Moreover, he was distressed by an awareness of his physical peculiarities, which caused the other boys to tease him when he was in swimming.

Now, I believe you can comprehend how little can be expected from the clinic alone in a case such as this. First, there is the necessity of informing the family of the patient's intellectual limitations and his physical abnormalities, with a view to correcting faulty attitudes and to improving the family situation as it relates to the patient. In addition, one must give thought to furthering the boy's education in accordance with his mental capacities and particular aptitudes. We should aid him in attaining a better adjustment with his own age group, through youth organizations, church societies and clubs. He is in need of medical treatment for his particular glandular disorder. Lastly, we must cooperate with the court in an effort to determine what methods of procedure are most likely to assist him in acquiring a code of ethics which will meet with the approval of society.

In conclusion, I wish to state that child guidance is the responsibility of the whole community, and that the community, if sufficiently enlightened, will not lose faith in child psychiatry but will be aroused to greater effort, rather than grow cynical in the face of what may at times seem to be inadequate results.

DR. BONHAM: A typical case study, in which the clinic helps adjust the child to his own home will be discussed by Dr. Anna C. Gronlund, also of the Marcy Hospital, under the title of "A Tip to Mother."

DR. GRONLUND: Jackie was only 10 years old, but he was growing up. He was reaching out into his environment for experience and knowledge. He was entering the period of gang activities. He was aggressive by nature, unusually bright, and had a host of friends. He sought recognition from his pals by leading escapades and treating them with candy which he purchased with stolen money. Thus he got into difficulties!

His escapades kept him out late; and their nature was such that he couldn't tell his parents. He then resorted to lies; for if he told the truth, he would be punished. The well-meaning parents attempted to enforce stricter discipline and punishment, with the result that he resented authority and his conduct became worse. Loose change about the house disappeared. When he was questioned about it, more lies were told. Now he was definitely at odds with his parents. Jackie felt that his parents didn't trust him, that they didn't love him as much as they did his brother. The parents in turn worried about having a boy who was a thief and possibly a future criminal.

Jackie attended the child guidance clinic where he had an opportunity to present his side of the problem. His interests were camping, hiking, and gang or club activities with other boys. He said his parents wouldn't let him have company at home because they objected to the noise. He told of his experience when he asked his father if he could have a birthday party. His father said, "If you give up the idea of a birthday party, I'll give you a dollar." He accepted the money; but it was immediately put into his savings account. His visions of "throwing" a party at the local ice cream parlor vanished. He wishfully related how one of his pals had made a coal bin into a club room and how the boy's mother treated the boys with jam sandwiches, cookies, etc. He added, "Gee, she is a swell mother."

The psychometric examination gave him an I. Q. of 110. He was correctly placed in school.

This boy's problem was simple. All he wanted was to be a normal boy, to enter into normal activities, and to pursue the normal pathway of growing up. His parents didn't understand his boyish gregarious cravings and wanted him to act as a little adult in the home.

The mother, however, was intelligent, willing and interested. It took only a few minutes for her to see the point. Her boy wasn't a thief and criminal. He was merely misguided and thwarted in carrying out his de-

sires. Her faith in him was being restored, and she was able to look at the problem from his point of view. Thus fortified, she went home to continue her task of bringing up Jackie.

All that was needed to bring about a change in the boy was an understanding attitude on the part of the parents, an opportunity for him to satisfy his social cravings in the home, and restoration of faith. She had no further trouble with him. She gained a boy to be proud of; and he gained a home to grow up in. We can sum up as follows:

Expended—one clinic visit.

Gained—a boy the mother can be proud of. A future good citizen. An understanding mother. And a lot of happiness for all concerned.

DR. BONHAM: The problem of children who are not in their own homes, together with the necessity of cooperation with local authorities, will be presented to us by Dr. Marion Collins, of the State Mental Hygiene Department, in a paper called "Josephine."

DR. COLLINS: An important phase of the child guidance clinics is their cooperation with the local staffs dealing with children who are not in their own homes. The case of Josephine illustrates this and also throws light on some of the needs of these children, needs which go far deeper than provision for food and shelter and schools. Josephine was the child of a woman unfit mentally and morally to take care of her, with the result that when the child, at the age of 11, was first seen in a child guidance clinic she had spent all her life in Homes spelled with a capital letter.

She had no family ties, no visitors to boast about and no one to take the place of a mother. She showed a conscious craving for a mother by saying in the clinic interview, "I think I have a mother somewhere, and when I make my Novena I offer it for her." She was a large-boned girl of boyish build and her hands were conspicuously scratched. In explanation, she said, "I fight. I don't scratch, I fight with my fists, but we fight a lot." It was fighting and bad temper that made her lose privileges; and she finally came out in such open rebellion that the orphanage wished to have her transferred to a correctional institution. She had a strong urge for recognition and said at the clinic that she would like to be a "Western girl—a cowgirl." She could not get recognition for good scholarship as she was dull, but she could always get attention by means of a good fight.

The clinic advised a boarding home which would give her someone to act as a mother substitute. The home was selected with care; and many of its activities were congenial to her, but, unfortunately for Josephine, a nice, quiet, obedient boarding child earned the praises of the foster mother, so she still failed to get recognition and still had no mother substitute. She

took no pride in her appearance and still fought with other children. When, finally, in a fit of rage, she maliciously threw the meat chopper at a member of the family, it was evidently time to try another boarding home.

Again the aim was to find a foster mother who could command respect and affection. Josephine was greeted at her next boarding home by a middle-aged woman who came toward her saying, "I have always wanted a daughter and now I am going to have one." Josephine responded as a flower to the sun. She was the only child in the family, and she identified herself with the home and helped with home plans. She learned to take correction and found that fighting is not socially acceptable. She has been in this foster home for two years now. For the past year there has been steady improvement. This fall the school reports are favorable. She has even been willing and glad to have another boarding child in the home, a sure indication that she feels secure in her relationships there. She is now just 13 years old.

Our clinic experience shows that discontent and unsatisfied cravings often express themselves in misbehavior. Josephine wanted recognition. She also wanted a mother. She has found both through the efforts of the children's agents. She knows that she can keep them only by deserving them. The clinic has helped by interpreting her needs; and the happy outcome has been the result of the fine cooperation of the foster mother, the schools and the social workers.

DR. BONHAM: We are indeed indebted to these speakers for their lucid presentation of the various phases of our subject. In the light of their words and the statistics presented, you will realize that a great work is being done in Oneida County in the problem of child guidance. The Mental Hygiene Department would be the first to admit that not all is being done that it could wish. But remember that the last Legislature reduced the appropriation for the Department of Mental Hygiene. More clinics will require an increased personnel. It is for you, the taxpayers, to say if you wish this. If you do, make your wishes known to your representatives at Albany.

Our chief speaker this evening is Dr. Victor H. Vogel (Master of Public Health), a representative of the United States Public Health Service, who has had a breadth of experience. Since 1931, he has been: Commissioned Officer of the United States Public Health Service, mostly in Mental Hygiene Division, including assignments at Federal Narcotic Farms in Lexington, Kentucky, and Fort Worth, Texas. Now Assistant Chief, Mental

Hygiene Division, United States Public Health Service, acting as Mental Hygiene Consultant to the states in a program designed to emphasize the public health aspects of mental hygiene and promote state mental hygiene programs in the health department of states where programs are not already established elsewhere in the state government. It gives me great pleasure to present Dr. Vogel.

(Dr. Vogel's address appears on pp. 110 to 119).

ROBERT WOODMAN, AN APPRECIATION*

BY JOHN R. ROSS, M. D.

After 42 years of active service in the Department of Mental Hygiene, all of which were spent at the Middletown State Homeopathic Hospital, Dr. Robert Woodman elected to retire to private life on October 31, 1940.

I feel that I have been signally honored in being selected to express the appreiation of Dr. Woodman's services to the State of New York and to speak of the high regard and esteem in which he is held, not only in the department, but elsewhere generally.

It has been my good fortune to have been rather intimately associated with Dr. Woodman on a number of committees. I have been a visitor at his home, and he has been a guest at mine. I have played golf with him and have been his traveling companion for weeks at a time when, with Dr. Storrs, we visited various institutions in Massachusettts, Illinois, the District of Columbia and all of the hospitals and schools under the control of the Department of Mental Hygiene in the State of New York, for the purpose of preparing a report on the workability of an eight-hour day. I feel, therefore, that I can speak about Dr. Woodman as one "having authority and not as the scribes."

Dr. Woodman was born in Bucks County, Pennsylvania of Quaker stock. His parents were birthright members of the Society of Friends in that section of the state which was settled almost exclusively by them. He received his preliminary education in the country school until the age of 15, at which time he went to the Abbington Friends School at Jenkinstown, Pa., from which he was graduated in 1892. The following fall he entered Hahnemann Medical College in Philadelphia where he completed the prescribed three-year course in medicine in the spring of 1895, at the age of 20, graduating No. 2 in his class. Because of his youth, he was not eligible to receive his degree until one year later. He accepted an interneship at the Rochester Homeopathic Hospital where he remained for two years. In the spring of 1897, he opened an office for general practice in Lambertsville, N. J., but missing his associates in the hospital and as he says himself, "not being tremendously prosperous in general practice," he made inquiry about a position at the Gowanda State Homeopathic Hospital which was at that time in the process of organization. After civil service examinations, he was ap-

*Read at the quarterly conference at the New York State Psychiatric Institute and Hospital, December 21, 1940.

pointed medical interne at the Middletown State Homeopathic Hospital in 1898, and one month later was promoted to junior physician. In August, 1900, he was appointed assistant physician. About this time, he took an examination for physician at the Eastern Reformatory at Napanoch and stood No. 1 on the list. An appointment was offered to him, but, on the advice of Dr. Talbot, then superintendent of the Middletown State Homeopathic Hospital, he refused it. In 1901, he was promoted to be a second assistant physician. The same year he took a civil service examination for optical surgeon and passed No. 3. From that time on, he did all of the eye refractions at the Middletown State Homeopathic Hospital. He was No. 3 on the first assistant's list in an examination held in 1901, and he was appointed first assistant at Middletown, October 1, 1902. On the retirement of Dr. Ashley, he was made superintendent of the Middletown State Homeopathic Hospital on July 1, 1923, and was superintendent of that institution until the time of his retirement.

Dr. Woodman has served on various committees in the department. He was for a long time a member of the training school committee, and after the retirement of Dr. Taddiken became its chairman. He was designated the chairman of the home and community care committee from the time of its inception, and his methods of placing patients in "family care" have been generally accepted by other institutions in the department. He was chairman of the committee to study organization of the eight-hour day in the department. The report of this committee, written in the greater part by Dr. Woodman, was accepted as the basis for the eight-hour day now in force. In 1933, he was appointed by Governor Lehman to examine persons under the sentence of death in Sing Sing Prison, and he was chairman of that committee at the time of his retirement.

Dr. Woodman is a capable psychiatrist, and because of his sound psychiatric understanding and judgment, poise and evident honesty and sincerity, he made an impressive witness and was much in demand as a medical expert by many of the district attorneys in the mid-Hudson area.

As an administrator and organizer, he was a conspicuous success. A visit to the Middletown State Homeopathic Hospital would suffice to assure one promptly of this fact. He stood for everything that was good and best in the department. He studied all problems thoroughly before making a decision; and when his mind was made up, he never deviated from what he considered to be right. He was fair and just in the management of em-

ployees and was always ready to temper justice with mercy. The loyalty of his employees speaks for itself as to their regard for his justness and fairness in his administrative capacities.

I do not recollect ever seeing Dr. Woodman upset or displaying anger. He is a kind, considerate, whole-souled gentleman at all times. This, coupled with his keen sense of humor, good judgment and common sense, generally placed him on the right side of most questions.

In over 30 years that I have been in the department, I have never heard a single derogatory criticism of Dr. Woodman. However, I have often heard him extolled as a man of high honor, excellent judgment and unimpeachable character.

We wish him a long, healthy, happy and prosperous life in his retirement.

LEWIS MINTON FARRINGTON*

An Appreciation

BY FREDERICK W. PARSONS, M. D.

The Department of Mental Hygiene, with powers and responsibilities substantially unchanged, has continued for more than 50 years. During that period, from time to time, this group has suspended its consideration of the State's business to pay tribute to the memory of commissioners and former commissioners and to superintendents and those who once had been the chief administrator of an institution.

In 50 years there have been but four secretaries. One, the first, crowned with years and abounding vigor, is, happily, yet with us. Another occupies a dignified position of responsibility in a nearby city, retaining his interest in our work and occasionally attending our gatherings. One has recently departed this life, and it is of him that we now speak.

Lewis Minton Farrington was born in the Town of Wales, Erie County, New York, on May 17, 1878 and departed this life on August 30, 1940, in his 63rd year. He came of pioneer stock and it was his privilege to hear from the lips of his grandparents the story of their journey by ox cart from the family home in New England to the tract of land opened in the western part of New York State by the Holland Land Company. One of his uncles, as a young man, walked from East Aurora to Batavia, to investigate an invention, in those days thought to be marvelous. He returned with a contrivance which could be attached to a scythe, with which a man could harvest grain at an unheard-of rate. Thus, was the harvesting cradle introduced into the wilds of Erie County. It was upon this meat young Lewis fed and his imagination was stirred by the stories of his pioneering forebears.

There was the district school, probably the one room type, East Aurora High School and Keuka College from which he was graduated in 1904 with the degree of Bachelor of Science.

Lewis Farrington devoted a few months to a clerical position in Chicago and then, as a result of a civil service examination, got a place in the Manhattan State Hospital as a stenographer. Shortly, he was working for the superintendent and reporting medical meetings in New York City. On February 1, 1911, he came into the department's office as a stenographer, becoming assistant secretary six months later. Four years later, he assumed the duties of treasurer; and he became secretary on August 15, 1921.

*Read at the quarterly conference at the Middletown State Homeopathic Hospital, September 21, 1940. See pp. 93 and 94.

Thus, for 35 years he worked for New York State, 19 of them in a position which, at an earlier day, might have been called "the clerk of the works." It is expected Mr. Farrington would have relished the title. It is as simple as he was. He never thought of himself as the god of the machine.

Mr. Farrington married Myrtle Briggs, and there survives his widow and two children, a daughter who has made her start in the world and a son in Hobart College.

It is extraordinary how efficient Mr. Farrington was in his work. In his quiet, unhurried way he accomplished much. He was never flustered; and no matter how busy, he gave undivided attention to problems which, strictly speaking, were not his but which were laid at his door by those in trouble. The woes of others were matters of his deep concern; and many are those who were benefited by his patient attention and wise counsel.

Artistic mastery in a painting is shown by some lacy loveliness, as contrasted by the bolder strokes of the brush. Mr. Farrington painted the background of his daily life with a large generous sweep. Then from time to time there would be worked into the picture a bit of detail of great artistic merit. Thus he dealt with an industrial insurance policy on the life of a patient. Usually the policy had long since lapsed because of nonpayment of premium. From Mr. Farrington's hand would come forth a nice, simple recital of the story addressed to the insurance company. This invariably brought in reply a letter of equal politeness quoting the restrictive terms of the contract; but never was the door slammed in his face. A second persuasive letter recognized the limitations but called attention to the happiness and comfort which would have flowed had the conditions been otherwise. Then the company would reply to the effect that it was their custom to deal generously with the policyholder and inquire how the happy state of affairs desired by Mr. Farrington could legally be attained without a subsequent comeback. Thus the beneficent correspondence was continued, and common justice requires that it be stated that the insurance companies sought ways and means to overperform on their contracts. In these days of trial, it is edifying to consider the spectacle of a busy State official and an important insurance executive conspiring together so that some poor friendless patient might have 25 cents a week with which to purchase something needful or to fritter away on inconsequentials. These pleasant interchanges of the amenities were always successful. They gave abounding satisfaction to Mr. Farrington, and let us hope that the insurance official went his way equally rewarded.

In going about the State visiting our far-flung institutions, there are necessarily rather long automobile journeys. On these trips, Mr. Farrington could be silent and he could talk entertainingly. He read deeply and understandingly and had a fund of information which he interpreted with an occasional quaint and arresting turn of phrase. He was a sparing but a delightful conversationalist.

Could he have lived to enjoy leisure, to ponder further and to evolve a philosophy of living out of the richness of his intellectual life, he would have left an even greater heritage. He would have needed few wordly goods. The quiet tree-lined village street, the century-old house, whose every hewn oaken beam he loved—and whose hand wrought iron nails showing through the worn, wide, clear pine floor gave him pleasure—all would have provided a setting from which might have come worthwhile thoughts of peace and contentment. They would not have been expressed by stirring words ringing in his hearer's ears. Rather would they have been gentle words, kind thoughts and loving memories, as quiet as the little mill stream at the end of his garden. Thus he would have enriched his busy, useful and productive life.

NEWS OF THE STATE INSTITUTIONS FOR THE HALF-YEAR PERIOD FROM JULY 1 TO DECEMBER 31, 1940

NEW INSTITUTION FEATURES, ADMINISTRATION, CONSTRUCTION, MAJOR IMPROVEMENTS, OCCUPANCY OF NEW BUILDINGS, ETC.

STATE HOSPITALS

Binghamton

The new dairy barn, in the rear of Orchard House farm cottage, has been completed.

The work of installing new drain pipes from the roof of the main bulding, to replace worn-out pipes, has been completed.

L. B. Strandberg & Son, of Chicago, contractors for construction work for the new power house, began excavating for the foundation during the month of August. Excavation for a new eight-truck garage, to be built under WPA auspices, was begun during August.

A toilet and lavatory were installed in the room adjoining the patients' dormitory, at Parkhurst cottage; a new bath tub, toilet and lavatory were installed on the second floor of this cottage for the use of employees. Toilets have also been installed on wards 10 and 14 in the north building, for employees.

Alterations have been made in the physician's apartment in the west building and an additional room provided.

Five hundred feet of two-inch extra heavy steam line was installed in new six-inch Rie-wil conduit from the north building to the superintendent's residence.

WPA workers have painted the exteriors of south, west, and main buildings, Parkhurst farm barn, entrance to assembly hall, Highland cottage, entrance to Broadmoor, ice house, garage and shop in rear of the farm barn, and roof of main building. Wards 20, 21, 22 and 23 in the main building were also painted.

Brooklyn

The four additional stories to the wings of building 10 were occupied during August and September.

The erection of a steel frame fence along Utica avenue, and of the retaining wall of steel fence along the Winthrop street side of the property, was completed during July.

The new electrical shop was completed and occupied during December.

Painting of the interior of building 10 has continued and is practically 95 per cent complete. The exterior trim of this building has been repainted.

Contract for insect screens for the new wards in building 10, awarded to the Orange Screen Company, is 25 per cent complete.

Work on the new physical therapy and indoor exercise building was started in August and has progressed quite satisfactorily. The foundations have been poured and the basement walls completed. The floor slab was poured during the last week in December.

New reinforced concrete loading platforms have been constructed at the laundry building.

The old barn, built in 1854, was demolished during September and is being replaced by an extension to the existing shop building, the foundations for which have recently been poured.

A new entrance has been constructed to the old staff kitchen, which is about to be used as a patients' library.

Postal sub-station 226, which has occupied quarters on the first floor of the Hugo Hirsh building, has been materially enlarged by taking in considerable space formerly occupied by the patients' library; and additional mail boxes have been purchased. This change was made necessary by the fact that the hospital has more than doubled in capacity during the past five years.

A considerable number of concrete benches, similar to those in the municipal parks, have been constructed to the north of building 10 and along the walks of the hospital grounds.

Landscaping around the wings of building 10 is practically complete.

A new public address system has been purchased and installed in the assembly hall.

The electrical contract in the additional stories to the wings of building 10 had been materially delayed, but was finished during the last week in December.

Central Islip

Construction work on the contract for addition to building 75, in new tubercular group; two single staff buildings; maintenance building; and addition to dining room, James group; was advanced to 99 per cent of completion.

Construction work on the contract for the employees' home; the automobile storage building; and laundry building; was advanced to 83 per cent of completion.

A contract for grading, walks and roads, about the new tubercular group and staff buildings 88, 89 and 90, was completed in November, 1940.

A contract was awarded covering the kitchen and dining room equipment for the main kitchen, dining rooms, and diet kitchens, in the new tubercular group; kitchen equipment for staff building 88; and cafeteria equipment in the new addition to the employees' dining room, James group.

A new 120-inch drier was installed in the laundry.

Four 100-gallon aluminum kettles, two vegetable steamers, and three 80-quart mixers were installed in the older kitchens of the institution.

Rewiring of six wards, dining room and kitchen, of group H, was advanced to 72 per cent of completion.

A Federal Works Project, including general repairs to buildings in north and south colonies, interior and exterior, was completed in October, 1940.

Creedmoor

The serving room equipment contract for the new reception building was not completed until October, some eight months late, but the women's side of the building was opened on July 16 and the men's side on August 12. The opening of this building increased Creedmoor's certified capacity by 400 to a total of 3,904. The contract of the Orange Screen Company for window screens and a few miscellaneous items in the reception building was completed; and during the half year two small contracts were let and finished: the painting of the interior of the water tank and repairs to the roof of kitchen building 1. At the end of the year, no contracts were in force at Creedmoor.

The following WPA jobs have been completed: alterations to the interior of cottage 3, which converted this building into two housekeeping apartments; installation of ladders and walkways in the power house; the building of a six-car brick garage and completion of the replacement of pipe in steam tunnels. With what has been done since the last report, a total of 11,536 lineal feet of pipe has been renewed.

The major WPA projects now under way at Creedmoor are an underground addition to the power house and a new hot water system for laundry, 38 per cent advanced; the installation of a new ammonia compressor, new brine tank, etc., kitchen building No. 1, 98 per cent; the building of a brick storage building, 35 per cent; the repair of plaster walls in the storehouse, bakery and vegetable preparation building, 23 per cent; the renovation of the interior of kitchen No. 1, 45 per cent; the erection of an extension to the shop building, 21 per cent; the construction of enclosures for walks between buildings O and P, the kitchen building No. 1, 17 per cent; alterations to the interior of the fire house, 9 per cent; the replace-

ment of corroded galvanized iron water lines with brass pipe, particularly in patient building O, 2 per cent. WPA painters and our maintenance crew did a great deal of painting, particularly exterior metal work, such as porch and window guards, areaway gratings, etc., on all the buildings. They also painted the exteriors of the wooden cottages, the picket fence, lamp posts, hydrants, etc., besides several thousand feet of cyclone fence and interior painting of some rooms and halls in employee buildings D, E, F, and I. Landscaping and grading was done in the H-I-K and B-C-D quadrangles, also in the cottage area and north of kitchen building No. 2; but with the onset of cold weather, the type of labor and foremen supplied was so poor that this work was discontinued until spring. Three thousand nine hundred and ten feet of nine-foot cement road was laid, 122 feet of 12-foot, 26 feet of 14-foot and 20 feet of 20-foot; also 2,023 lineal feet of curbing and 532 lineal feet of side walk.

It is becoming increasingly difficult to obtain materials for the WPA jobs, particularly anything in steel.

Gowanda

A number of WPA projects have been completed during the period, including the placing of curbing, improvement of road shoulders and reconstruction of the drainage system in front of The Pines and White Lodge. A considerable length of road has been resurfaced, and a number of parking spaces have also been completed.

Hudson River

Two projects under special fund estimate for changing from indirect to direct heating system on wards 4, 8 and 16, south wing, and wards main 2, 3, and 4, 19 and 20, north wing, main building, have geen completed. The construction of a fire escape and recreation porch for wards 1, 5 and 9, south wing, main building, for which an appropriation of $18,000 was made, has been finished.

The installation of a new cafeteria type dining room on the north wing, main building, for patients' use, has been completed. This dining room replaces three former dining rooms in this building. A new dining room for employees, equipped cafeteria style, has been put in operation in the north wing of the main building.

The reconstruction of a pavilion used for patients' dances in the summer months, has been completed. Two outside pavilions, seating 200 patients, each, have been completed in the rear of the Ryon Hall building.

Roof repairs have been made to the main building, to the extent of the funds provided. The repairs to walls of boiler No. 5 have been finished at a cost of approximately $4,000. Two new boilers equipped with stoker equipment, have been installed in Cleveland home.

The contract for the installation of an electric dumbwaiter, in the north wing of the main building, has been completed.

A mobile Cambridge electrocardiograph machine has been purchased for the hospital.

One 40-inch Hoffman extractor has been installed in the laundry.

One Dutchess two-pocket divider has been installed in the bakery.

Kings Park

Three roads have been completed as a WPA project. One is at group 4, another is a connecting road between the boulevard and the Old Dock road and the third is a road around group I. Concrete walks and curbs also have been laid.

The entire interior of the administration building was painted under a WPA contract.

The superintendent's residence, five-family and seven-family staff houses, propagating house, garage and continued treatment building for 400 male patients are completed.

Marcy

The WPA project of $30,705 for the construction of tunnels to replace two old Mansville tunnels was started on September 23, 1940, and is about 25 per cent completed.

In August, 1940, the WPA allotted $7,266 for the project of exterior painting of A, C and D and the exterior and interior painting of the farm colony and administration building. Work was started on this project on October 5, 1940, and is now about 55 per cent completed. The exterior painting of the farm colony and administration building has been completed, and the exterior painting of C building is about one-half done; but further work on this will have to be discontinued until next spring. The interior painting of the farm colony has also been completed. Interior painting of the administration building is now in progress.

In October, the work of replacing, with lead-coated copper, the valleys and flashings of the roofs of employees' homes, Bywood, Inwood and Northwood was completed. The metal was also extended over the edges of the roofs to form drips and prevent backing up of water from melting ice in the winter time.

The WPA project of $35,064 for grading, seeding, leveling and terracing of the lawns, and for stump removal, which was started in October, 1939, was completed in October, 1940.

The roofs of the tunnels leading to F building and G building, which are used as a front walk for these buildings have been resurfaced.

A vacant dining room on the male side of the west group dining rooms has been partitioned and repainted. This is to be used by the WPA workers assigned to this hospital by the New York State art project.

Middletown

Extensive repairs to the amusement hall have been completed under a WPA project. They include the laying of a new floor, reparis to stained glass windows, complete redecoration of the stage with new scenery, and repainting of the entire interior. Two new moving picture machines have been installed in a newly built fireproof booth, with equipment for broadcasting records through a loud speaker adjustment and with a magic lantern attachment for the display of slides.

Extensive repainting of wards in many of the buildings has been completed under a WPA project.

The extension of concrete roads about the grounds of the hospital is continuing; and during the past year 7,548 square feet of road and 180 linear feet of gutter have been completed.

Pilgrim

On July 23, L. I. Kibbe, research engineer of the State Architect's office, Albany, came to the hospital to start a study of the action of various makes of thermostatic valves.

During July, a tennis court for female employees was completed.

On August 8, the WPA officially started work on the basement of the assembly hall, which when completed, will furnish a community store, a bowling alley, a recreation room for employees and a library for patients.

On August 28, building 28 was opened; and one ward for males and one for females were put in use. For some time, the commissioner and the superintendent have considered the use of this building for a study of dementia præcox. It has been felt that here is an opportunity to gather a relatively large group of dementia præcox cases where all theories relative to treatment may be tried and compared, and where possibly new research projects may be instituted. All our insulin and metrazol therapy is now being carried out in this building. On October 20, in carrying out the idea of research in our new building 28, electric shock therapy was instituted.

On September 16, the nurses' training school of this hospital was officially opened. During the past year, modern, up-to-date equipment for the training school, complete to the last detail, had been installed but considerable difficulty was experienced in procuring the proper personnel. The school opened with 11 students.

On November 16, a branch postoffice of the postoffice at Brentwood, was opened at the hospital. It is hoped that this will facilitate the rapid delivery of mail for patients, employees and the hospital.

On December 30, 1,514 feet of new concrete road were completed by the WPA and opened to traffic. With the completion of this road, all buildings now have either concrete or bituminous service roads.

The construction of buildings 81, 82 and 83 continued steadily during the past six months; and at the end of December the brick work had been completed, the windows had been glazed; and on several floors the plastering had also been completed.

Rochester

Changed methods of delivery of supplies to the hospital have made it necessary to provide accommodations at our storehouse for trailer trucks. To accomplish this, it was necessary to excavate a large turning area to admit these trucks to our platform. This work was completed early in the summer.

The last Legislature provided funds for the purchase of materials to resurface some of the roads adjacent to the industrial buildings and approaches to parking places. This work was completed early in the summer.

Thirty-five roof ventilators on the buildings south of Elmwood avenue have been either replaced entirely or repaired.

About the first of November, a WPA project was begun on a vegetable preparation building which has been located conveniently to root cellars and accessible to hot and cold water supplies. This is probably about 70 per cent completed.

Late in November contractors for the installation of an electric elevator in the storehouse, started work. Slow progress has been made, due to delay in delivery of parts necessary for the foundation. The brick work of the elevator shaft is largely completed, but there is no roof over it.

The second floor of the old laundry building, which has been used for some years as a storage place for hospital supplies, has been remodeled to accommodate the clothing clerks and the equipment and supplies with which they deal. The result is centralization and more compact facilities than those which have been available.

Ever since the nurses' home was built in 1930, the back door entrance has given considerable trouble when there were heavy storms. The drain at the foot of the stairway would freeze, and the water would run into the basement. To obviate this, a kiosk was installed; and up to the present time it appears to have fulfilled its purpose.

Rockland

The addition to the laundry building, begun last spring, is progressing satisfactorily and is now approximately 99 per cent completed.

Concrete sidewalks have been laid between buildings 38, 34 and 32.

Extensive repairs, plastering and painting have been completed in the administration building. All of the staff cottages have been painted, and the interiors and exteriors of several of the frame farm cottages have been painted.

Extensive grading and seeding has been done between buildings 32 and 34.

New gas ranges have been installed in kitchen 4 to replace the coal ranges.

Four additional bed pan sterilizers have been installed in building 57.

A new four-channel electroencephalograph was purchased with funds from the hospital exchange and placed in building 57.

The cut stone steps leading to building 57 have been completed.

St. Lawrence

Under special fund appropriation, tie rods were placed in the east dairy barn; new roofs were placed on silos; roofs and gutters were repaired; water lines were renewed; and work was carried forward on the reconstruction of connecting corridors in the main building.

At the boiler house, a wooden enclosure was made for the pumps, above which a small room was constructed to serve as a dining room for firemen and engineers.

An additional parking space was constructed at the executive center, and sub-basing and widening of roads were begun.

Under a WPA project, 37,000 feet of new cable were laid; and additional lights were installed for the outside lighting of the grounds. The WPA project for reconstruction of the piggery is nearing completion, and that for the clearing of woods and painting is in progress.

Willard

A new concrete stave silo has been constructed at the grange; contract for this was let to the Marietta Concrete Corporation, Marietta, O.

Reconstruction has been completed at Grand View for the installation of a central clothing room.

Secondary roads, leading to Maples, Sunnycroft, fire house, grange and staff buildings, were built.

Under WPA projects, two wooden towers on the assembly hall were removed and a new roof was installed. The exterior wood work trim of the hall has been repainted.

Renovation, including plastering and painting, of the interior of two ward buildings (Maples and Sunnycroft) is advancing.

Syracuse Psychopathic

During September, the entrance porch to the hospital and the windows and bars on the exterior of the building were painted.

During November, the two parking spaces at the rear of the hospital were resurfaced, because the concrete was showing wear and disintegration. The labor was furnished by the Department of Public Works.

STATE INSTITUTIONS

Letchworth Village

The work on the contracts for the addition to Cottage Beta and the hospital building have been officially completed. These extensions are now occupied and can accommodate 58 patients.

The work on the contract for waterproofing the walls of the basement of Franklin has also been completed. The basement of this building is used as an employees' recreational center. It is hoped that this work will correct the seepage of water through the walls and floor, a condition which has existed for some time.

Groups of boys have been employed laying new concrete and cinder roads and enlarging parking places about the grounds.

Individual drinking fountains have been installed in various buildings.

Newark State School

A new 50-foot steel flagpole was erected in front of the adminsitration building, and a new six by 10-foot American flag and a five by eight-foot State flag were procured.

The print shop was enlarged and a new printing press was installed. A new floor was laid in the corridor of the "A" building. Additional playground equipment was purchased and installed. Hose cart buildings, with new hose cart and hose, have been acquired for the farm colony.

A professional exterminator company was employed to eliminate roaches and other vermin from the school premises.

Two truck loads of shrubbery, removed from along route No. 20, were donated by the State Highway Department. This has been used to advantage about the school grounds.

The telephone switchboard, on the first floor of "A" building, was partially enclosed with glass to protect the operators from drafts.

The exterior of the superintendent's, clinical director's and steward's residences, and the Nevin home, were painted by institution and WPA painters.

A WPA Art Project for new curtains for the stage of the auditorium was approved; and work started.

The WPA work completed during the past six months has been as follows: Grading of grounds between the east dormitory and Maple avenue and Vienna street, and in front of and back of "A" building; construction of cement walks to replace walks from the south entrance of "C" building and those leading from the "C" building to the girls' hospital and near the school building; the building of cement platforms for metal swings back of "A", "B" and "C" buildings; the construction of cement steps from the propagating house to the top of the grading leading to the barn; the replacement of the roof over part of the power plant on the south and east sides; the construction of outside entrances to the basement of the east and west wings of the boys' hospital building; and the construction of a secondary road back of "A" building.

Roads about the athletic field, the superintendent's, the clinical director's and steward's residences and the Nevin home, were oiled and covered with fine gravel by the WPA. The temporary bridge, at the north entrance of the barn at the school colony farm, was replaced with one of cement and steel construction; the boiler house, barn and adjoining buildings were painted, and at present the painting of the interior of the south and west dormitories is progressing satisfactorily. These are all WPA projects.

Wassaic State School

A new wagon shed has been completed near the horse barn. The south end is constructed of stone and will be used as a harness room.

A club house is being erected at the employees' recreation park and swimming pool. This building contains lockers and showers for bathers in the summer, and a large fireplace equipped with a Heatilator for skaters during the winter months. Considerable grading and seeding was completed in the vicinity of the bathing pool during the fall.

A new flagpole has been erected in front of the girls' school building.

NOTEWORTHY OCCURRENCES

STATE HOSPITALS

BINGHAMTON

The survey, for the detection of tuberculosis, which was begun in the west building, was continued in the south building. All patients and employees were tested with the Mantoux test; and positive reactors were X-rayed. Three hundred and five patients and 50 employees in the south and west buildings reacted positively. Only one patient was found to have active tuberculosis. Five employees and 41 patients were found to have arrested tuberculosis. All of these persons will be carefully watched; and X-rays of the chest will be taken every six months.

Dr. George Webber, of the State Department of Health, arranged on August 21 for a survey for tuberculosis of all patients and employees in the hospital, with the purpose of testing a 35 mm. X-ray roll film, a 4x5 pack film and the standard 14x17 chest film, to determine whether it might not be possible—through a test of 1,000 patients—to use a cheaper film than the standard chest film. Dr. Webber returned to the hospital September 9, gave a talk to members of the medical and nursing staff and showed films demonstrating tuberculosis of the lungs. On the same date, technicians from the General Electric and Westinghouse Companies arrived and installed X-ray machines for the survey. X-rays of the chests of 1,000 patients were taken. When the study of the results of the three films used has been completed, the survey will be resumed; and X-rays of the chests of the officers, employees and the remaining patients will be taken.

Registration of alien patients in the hospitals was begun in September, with a total of 434 registered. These patients were finger-printed by Federal employees during November.

Arrangements have been made for the registration of all male patients between the ages of 21 and 36, inclusive, before they leave the hospital on parole or discharge, in accordance with the Selective Service Law.

Abbott Low Moffat, chairman, and Charles P. Locke, secretary of the Ways and Means Committee of the New York State Assembly; with Senator Roy M. Page and Assemblyman Edward E. Walters of Binghamton, visited the hospital, August 8, and inspected all buildings housing patients; the laundry, assembly hall, the site of the new power house, and the new farm barn. They made a tour of the hospital farms.

Henry Ryon, senior sanitary engineer of the Department of Public Works, visited the hospital in August, inspected the hospital reservoir, which was leaking badly, and advised the hospital on a remedy for the situation.

Dr. H. K. Spangler, field representative, Council on Medical Education, of the American Medical Association, visited the hospital September 7.

Dr.. James H. Lade, medical consultant, Division of Syphilis Control of the Department of Health, visited the hospital, September 4, October 22 and 31, to discuss the possibility of a collection of cerebrospinal fluid specimens in the hospital, for a proposed comparison between the New York State titer and other methods of quantitative determinations of the complement fixation reaction in the cerebrospinal fluid.

William E. Haugaard, commissioner of architecture, visited the hosptial October 1 and inspected work at the site of the new power house.

Dr. R. J. Young, assistant physician, left October 7, to attend a 10-weeks course at the Psychiatric Institute and Hospital.

In accordance with instructions from the Department of Civil Service, all employees reporting for work after November 1, 1940, have been fingerprinted; and copies of their fingerprints have been forwarded to the Department of Civil Service.

Oscar S. Parker, field representative of the Department of Civil Service, called at the hospital December 16 and outlined the methods which the Civil Service Department proposes to follow in making available attendants to be employed by the hosptial after January 1, 1941.

Graduation exercises were held in the assembly hall September 11. Four women and two men were graduated from the School of Nursing.

The usual Christmas parties were held for patients; and on the afternoon of December 23 the hospital's Christmas party was held in the assembly hall, under the direction of Dr. Harold A. Pooler. The entertainment was by patients in the occupational therapy department, and by students in the nurses training school and other employees, with several special acts by young people from the city.

On December 20, Mrs. Helen VanWhy, of Binghamton, gave a Christmas party for ex-service patients, on ward 42, Broadmoor.

The annual Christmas sale of articles was held by the occupational therapy department, with proceeds of $300.

Miss Mary Kendall Gold, chief occupational therapist, retired on pension October 31.

Mrs. Rose Camp, attendant, died September 11, of pneumonia.

Brooklyn

On July 30, lightning struck the chimney of building 10, tearing two large holes in the north side and scattering a considerable amount of brick about. Fortunately no one was injured.

On September 1, the certified capacity of the hospital was increased from 2,203 to 2,603. This resulted from the completion of the additional stories to the wings of building 10.

Graduating exercises of the school of nursing were held on September 14. Five men and 14 women were graduated.

A meeting of the Tenth District Branch of the New York State Nurses' Association was held here on the evening of September 24.

On October 1, Dr. August E. Witzel, who had been director of clinical psychiatry here since November 10, 1925, resigned to become medical superintendent of the Newark State School, having been on leave of absence from the hospital since July 1 as acting medical inspector. On September 25, the members of the medical staff gave a dinner to Dr. and Mrs. Witzel, in the officers' dining room of the Hugo Hirsh building. This was followed by a reception and dance in the assembly hall, given by the officers and employees, at which time a silver tea service was presented to Dr. and Mrs. Witzel.

Dr. Carmelo J. Chiarello, assistant physician, and Dr. Sidney L. Tamarin, assistant physician, attended the course in neurology and psychiatry at the Psychiatric Institute, from October 2 to December 10.

The custodians of the John and Mary Markle Foundation have granted $4,700 for research work in the treatment of dementia præcox with nitrogen anoxia. The work will be carried on at this hospital in collaboration with Dr. Harold E. Himwich, professor of pharmacology and physiology at the Albany Medical College.

The annual Christmas party for patients was held in the assembly hall on December 21. The affair was well attended and apparently much enjoyed by the patients and their friends.

BUFFALO

On July 25, Miss Mabel Wilcox, visitor of the State Charities Aid Association, visited and inspected the hospital.

On September 3 and 4, Dr. William J. Tiffany, commissioner of the Department of Mental Hygiene, visited and inspected the hospital, and met with the Board of Visitors to discuss budget requests.

Dr. H. Beckett Lang, superintendent, was appointed lecturer in clinical psychiatry at the University of Buffalo School of Medicine. Dr. Lang was also appointed lecturer in social psychiatry at the University of Buffalo School of Social Work.

At the regular monthly meeting of the Board of Visitors in October, Dr. Harry H. Ebberts and Mrs. John R. Hazel were reelected president and secretary respectively.

Dr. Bruno G. Schutkeker, senior assistant physician, and Dr. John F. McGowan, assistant physician, are on leave of absence from the hospital on military duty.

Miss Raphael Henry, social worker, was transferred to the Central Islip State Hospital, Central Islip, N. Y., on October 1, 1940, where she will hold the same postiion.

Mrs. Ruth B. Warren, assistant principal, school of nursing, resigned from the hospital on October 22.

Dr. H. W. Abrahamer, assistant physician, attended a course in neuropsychiatry at the Psychiatric Institute and Hospital, from October 7 to December 13.

A request from the graduate nurses of the hospital to retain the black band on their caps was referred to the committee on uniforms. The committee ruled that all graduate nurses may wear the black band.

The annual patients' field day was held July 2.

Graduation exercises of the school of nursing were held the evening of September 25. One man and eight women received diplomas.

Mrs. Theresa E. Pratt, chief occupational therapist, attended the meeting of the American Occupational Therapy Association in Boston, September 14-19.

The occupational therapy department held a successful exhibit and sale at the Erie County Fair, Hamburg, August 19-24.

Dr. Huston K. Spangler, field representative of the American College of Surgeons, visited the hospital to determine the quality of work in regard to the requirements of the college. On September 27, a letter was received from th American College of Surgeons stating that the hospital was again approved.

The following employees retired on pension during the past six months:

Frances Van Tassel, attendant (sewing room), July 31.

Clarence Krull, assistant engineer, September 30.

Jacob Casper, an attendant, died on August 13, of acute lobar pneumonia.

Central Islip

The Department of Civil Service held an examination here July 27 for the position of asssitant engineer, first grade. The examination was taken by seven of our employees.

Dr. William J. Tiffany, commissioner, visited the hosptial on August 21 and 22.

Suffolk County Fair was held at Riverhead from September 2 to September 7. Flowers, farm products and articles made by patients in the occupational therapy classes were exhibited and won many prizes. On September 5, the patients' band attended and, during the afternoon show, was asked to play alternate numbers with the professional band of the fair. This was the first time the band had visited the fair.

In September registration of all alien patients was begun in accordance with the Alien Registration Act.

Dr. David Corcoran, superintendent, attended a meeting of the Committee on Nursing of which he is a member, held at the Middletown State Hospital September 20. He also was present at the Quarterly Conference there September 21.

Five principals of the high schools in the surrounding area were guests of Mrs. Dorothy D. McLaughlin, principal of our school of nursing, on October 17 at a luncheon of the State League of Nursing Education. The discussion centered on desirable qualifications of student applicants.

The student council of our Training School for Nurses has purchased copies of the American Journal of Nursing dating back to 1911. These will be bound and added to the collection in the nurses' library.

Miss Raphael Henry was transferred from Buffalo State Hospital as social worker on October 1.

Mrs. Dorothy D. McLaughlin, principal of our School of Nursing, has been appointed chairman of the Committee on Mental Hygiene and Psychiatric Nursing by the State League of Nursing Education.

Two student nurses were sent as delegates to the annual luncheon of the National Committee on Mental Hygiene at the Hotel Roosevelt in New York City, November 14.

The response to the annual Red Cross Roll Call was gratifying, with $180 donated by the employees.

Dr. Aaron Moore, senior assistant physician, completed a post graduate course in neurology and psychiatry at the Psychiatric Institute and Hospital, New York City, in December.

Dr. Cecil L. Wittson, lieutenant in the United States Naval Reserve, was inducted into service, December 8. He is the first of the staff to be called and is temporarily stationed at Newport, R. I.

The following employees retired during the past six months:

Mary E. Nevins, charge attendant, July 31.

Bridget Fox, nurse, August 25.

Catherine Bradley, charge attendant, November 13.
Antoinette F. Duggan, special attendant, November 30.
George J. Seifert, attendant, November 30.
Annie M. Smythe, charge nurse, November 30.
Deaths during the same period were:
Mary E. Dunn, social worker, July 19.
Helen Congdon, attendant, August 25.
John Fitzgibbon, attendant, November 21.
Barney Hamill, clothing clerk, November 28.

Creedmoor

The first graduation exercises for the training school were on the evening of September 27.

On November 19, the Long Island Psychiatric Society met at Creedmoor The paper of the evening was by Dr. Foster Murray of Brooklyn on "Pathogenesis and Present-Day Treatment of Pulmonary Tuberculosis."

Two children in medical officers' families developed scarlet fever in October; but both recovered without complications, and no other cases developed.

On October 21, the hospital was approved by the American College of Surgeons.

During the Christmas holidays, the hospital, as usual, supplied all patient buildings and employee homes with trees; and many of the wards and buildings were attractively decorated. The annual Christmas vaudeville entertainment was given on December 20, and on the twenty-third a Christmas cantata with appropriate scenery was given by a group of employees. On December 24, 110 patients sang Christmas carols in the various buildings; and special parties were held on several days for working patients. On Christmas, gifts purchased from a donated fund were distributed to all friendless patients. Special dinners were served on Christmas and on Thanksgiving.

Gowanda

On September 7, a meeting of the Buffalo Neuro-psychiatric Society was held at the hospital. There was a golf tournament in the afternoon, followed by a picnic supper in the grove. A scientific program was held in the evening, the program being presented by members of the hospital staff.

The annual commencement exercises of the school of nursing were held on the evening of September 10, at which time 15 young women and men received their diplomas.

Sidney Hines, laundry supervisor, retired after 28 years of service.

Harlem Valley

The Dutchess County Psychiatrical Society met at the Harlem Valley State Hospital November 28. Dr. Barrera and Dr. Kalinowsky of the Psychiatric Institute, gave a talk on Electric Shock Therapy. Moving pictures of this treatment were shown.

Family care patients have increased during the past six months from 23 to 72. An appropriation for this work was granted to the institution on July 1.

The inter-hospital golf tournament was held at the hosptial September 11 and 12, and the cup was won by Dr. William F. Hayes, dental interne at the Harlem Valley State Hospital.

Dr. J. R. Haight and Dr. Thomas March, assistant physicians, took the 10-weeks' course at the Psychiatric Institute, New York City, beginning October 7.

Hudson River

On July 4, the annual field day and carnival was held at the recreation field. As usual, the general athletic events were partiepiated in by employees and patients. In the afternoon a baseball game was played between teams of this hospital and the Harlem Valley State Hospital.

On September 6, graduation exercises of the school of nursing took place. Four men and 16 women received diplomas. Prizes were presented by members of the board of visitors, Mrs. Charles J. Corbally and Mrs. Edward J. Conger.

The first meeting of the Public Health Nurses Staff Education Course was held at this hospital on October 15. Prof. Wall of New York University addressed about 100 nurses from Public Health Services and various adjacent hospitals.

Several members of the medical staff attended the meetings of the Dutchess County Psychiatrical Society at the Matteawan State Hospital, October 17, and at the Harlem Valley State Hospital, November 28.

On October 21, a moving picture of the hospital activities was presented to members of the Northern Dutchess Community Nursing Service at Rhinebeck, N. Y.

The appointment of the superintendent, Dr. Ralph P. Folsom, as a member of the Governor's Commission to examine the mental condition of prisoners under death sentence at Sing Sing Prison was received on October 25.

On December 4 and 5, Dr. E. R. Rickard, International Health Division, Rockefeller Institute, vaccinated about one-third of the patient population against an epidemic of influenza.

The usual Christmas festivities for patients were conducted. A moving picture and vaudeville program were given, followed by presentation of gifts to patients. As is customary, several large Christmas trees with colored lights were placed about the hospital grounds, and trees were placed in the various wards.

The following employees retired on pension during the past six-month period:

Daniel P. Ryan, master mechanic, July 31.

Ella Haynes, chambermaid and waitress, September 9.

Ernest D. Baker, attendant, November 27.

Anna Gutkowska, special attendant, December 1.

Forty-five employees went on military duty, September 16.

Four employees went on military duty, October 15.

Kings Park

Graduation exercises of the School of Nursing were held September 11. The address was given by Miss Emily J. Hicks, executive secretary, New York State Nurse Association. Thirteen women and two men were graduated.

The annual field day was held at Tiffany Field on August 14. A WPA band gave a program.

Major E. B. Carye, special assistant to Administration of Veterans' Affairs, and Dr. N. E. Stewart, clinical director, of the Veterans' Administration Facility, Northport, visited the hospital on August 13.

Mrs. Frederick L. Cranford, State Charities Aid Visitor, visited the hospital August 26. Miss Margaret Welsh of the National League of Nursing Education Accrediting Committee visited the hospital and training school November 26.

Representatives from the Nassau County Mental Hygiene Committee, Women's Auxiliary to the Nassau County Medical Society and the Hempstead-Garden City League of Women Voters visited the hospital December 10 to learn details of some of the work.

On December 9, a large percentage of the hospital employees and patients were immunized against influenza, under direction of Dr. E. R. Rickard of the International Health Division, The Rockefeller Foundation, New York City.

Dr. George Volow, senior assistant physician, returned to duty December 16, having completed a course of several weeks at the Psychiatric Institute, New York City.

Deaths:

James J. Kennedy, plumber and steamfitter's helper, on September 12.

Bert Walker, special attendant barber, November 22.

Retirements:

Peter Hildenbrand, photographer, on December 1, after a continuous service of 31 years.

Appointments:

Mrs. Pearl O. Chenoweth, assistant social worker, August 8.

Miss Alice Sowell, assistant social worker, November 16.

MANHATTAN

The graduation exercises of the school of nursing were held in the amusement hall the evening of October 15. Twenty-five graduating students, seven men and 18 women, received their diplomas and pins. The speaker was Dr. William Seaman Bainbridge.

Hallowe'en parties for the patients were held in the amusement hall Tuesday afternoon, October 28, and Wednesday evening, October 30. Approximately 722 patients attended.

A meeting of the Psychiatrical Society of the Metropolitan State Hospitals was held at the hospital on Monday evening, October 31. The following is the program:

1. Election of officers.

2. "Psychogalvanic Investigation in Psychoses." By Paul Hoch, M. D., and Joseph F. Kubis, Ph.D. and F. Rouke, M. D. Discussion: David Wechsler, M. D. and S. Eugene Barrera, M. D.

3. "Somatic Factors in Mental and Nervous Conditions with Illustrative Cases," William Seaman Bainbridge, M. D. Discussion: John R. Knapp, M. D., Graeme Hammond, M. D., A. A. Brill, M. D., and Irving J. Sperber, D. D. S.

Dr. William J. Tiffany, commissioner of mental hygiene, held a conference at the hospital on December 13 with William E. Haugaard, commissioner of architecture; Robert Moses, commissioner of parks; and George Spargo, executive officer, Department of Parks. They inspected the area east of the Triborough Bridge known as Area B, for the purpose of determining what portion of that area could be abandoned now or in the near future for further park development.

Twenty-five patients were transferred to the Middletown State Hospital on December 17.

State Senator Charles Muzzicato, accompanied by Dr. Martin Cohen, president of the Board of Visitors, and Dr. Hugh M. Cox of the same board, visited the hospital on December 17 in reference to the closing of the hospital in 1943 and the proposed demolition of certain buildings.

Several Christmas parties were held for patients. Twenty-four Christmas trees were distributed to various wards of the hospital. Candy and gifts were given to the patients.

A "Kiddie" show for patients was held in the amusement hall the evening of December 30 as arranged by the Society of the Friends of the Mentally Afflicted with Charles Lowe, proprietor of a dancing and theatrical school at 1697 Broadway, New York City. Approximately 470 patients attended this entertainment.

The following employees died during the six month period:

Robert Dann, special attendant baker, July 11.

Josephine Lenehan, special attendant technician, July 27.

Percy G. North, bridge guard, November 17.

John Carney, attendant, December 21.

Marcy

Mrs. Allen and Mrs. DeGraff, representatives of the State Charities Aid Association, made an official visit to the hospital on July 17.

Mrs. Annie D. Mills, a member of the Marcy State Hospital Board of Visitors, died September 25.

Huston K. Spangler, M. D., field representative of the American College of Surgeons made a survey of the hospital on September 23 in accordance with the hospital standardization program of the American College of Surgeons.

Samuel Cohen of the Department of Audit and Control visited the hospital on October 2, relative to the feasibility of instituting triplicate requisition blanks.

Dr. Frank Henne, assistant physician, left the hospital on October 5, to take a 10-weeks course in psychiatry conducted by the Psychiatric Institute. A Christmas party for ex-service patients was held in G building on December 24 under the direction of Mrs. Thomas Johnson and women of the American Legion and auxiliary.

On the evening of December 26, a Christmas entertainment was held for the patients in the assembly hall. A marionette show and other acts were presented by patients and employees. A Christmas box was given to each patient.

Middletown

The annual Field Day of the hospital was held July 31. This year, the program featured athletic events. Among the visitors, was James E. Simpson, supervisor of physical training.

Every Saturday during July and August, picnics were held for the patients at Fusco's Grove. These picnics include swimming, athletic activities and outdoor dancing, and are always greatly enjoyed by those of the patient population who are able to attend.

Through the courtesy of the directors of the Orange County Fair, about 400 patients attended the fair on August 20. The director of the amusement area gave many free tickets to the various amusements to the patients.

The annual commencement of the nurses' training school was September 18. Ten women and five men received their diplomas, which were presented by Miss Florence L. Ketchum, president of the Board of Visitors. Wendell Phillips, of Port Jervis, addressed the graduatees.

The quarterly conference of the Department of Mental Hygiene was held at this hospital on September 21.

Nine employees of the hospital were called into active duty with the national guard on September 15.

Through collaboration with the Rockefeller Institute, about 700 of our patient population and most of our employees have been inoculated with the vaccine for protection against influenza. This is a newly developed vaccine found to be effective against influenza A, the type of disease now prevalent in this country. The vaccine is composed of a mixture of the virus of influenza A and the virus of canine distemper.

Dr. Louis Berlatt returned to service December 16, following a 10-weeks' course of instruction at the Psychiatric Institute.

Miss Victoria Malecki of Utica, was appointed to the position of assistant social worker on October 1, 1940.

Pilgrim

The Long Island Psychiatric Society held the first of the 1940-1941 meetings on October 22, at this hospital and was addressed on electric shock therapy by Dr. Barrera of the Psychiatric Institute, and Dr. Kalinowsky of this hospital. Dr. Horowitz of the Institute discussed the paper. About 125 people attended the session and a great deal of interest was shown in this relatively new form of therapy.

Dr. Edward S. Rogers, director of the bureau of pneumonia control, State Board of Health, addressed the doctors of the staff and some of the nurses, on July 3, on the "Epidemiology of Pnemonia—Felton's Polysaccharides Antigen," and a résumé of the experiment at this hospital. On July 5, Dr. Wheeler repeated the lecture for the graduate nurses of the hospital.

Vincent J. Schiavoni, assistant architect of the Division of Architecture, Albany, came to the hospital on July 15 and remained for several days, taking interior and exterior photographs of a number of the buildings.

On July 16, Dr. William J. Tiffany, commissioner, and William Clifton, supervising power plant engineer, arrived at the hospital for the fall visit and on July 17 met with the board of visitors.

On July 30, Dr. Justin K. Spangler, field representative for the American College of Surgeons, came to the hospital to survey the work.

Dr. Maxwell Frank, assistant director of Mt. Sinai Hospital, New York City, called on the superintendent and was shown some of the work of the institution on August 19.

On August 25, at 1 o'clock a concert, followed by a drill by the 108th Squadron, Sons of the American Legion of Brooklyn, was given in the Nurses' Circle for the patients and employees. The program was enjoyed by 2,500 patients as well as employees and guests.

On August 28, Dr. S. Eugene Barrera, principal research psychiatrist of the Psychiatric Institute, visited the hospital.

On August 30, Dr. Louise Winder, medical director of Hastings Hillside Hospital, Hastings-on-Hudson, visited the hospital.

Miss Stella Hawkins, secretary of the State Board of Nurse Examiners, visited the hospital to see the equipment for the nurses' training school on September 6.

On October 16 and 17, the eighth semi-annual stewards' conference was held at this hospital. The sessions were well attended, and a keen interest was shown by all in the topics that were discussed.

On October 22, Miss C. Emily Todd, social worker, attended the meeting of the Long Island Psychiatric Society and Hospitals, and was elected secretary of the group.

Dr. W. R. Dunton, superintendent of Harlem Lodge, Catonsville, Md., and Dr. J. C. Coggins, superintendent of a sanitarium at Laurel, Md., visited the hospital and were shown through the buildings on October 22. They were especially interested in occupational therapy developments.

On October 30, Miss Covel, directress of nurses of the Neurological Institute, New York City, and Miss Penland, in charge of anesthesia of Columbia Presbyterian Hospital, together with 10 student nurses from the Presbyterian Hospital, visited this hospital, and were shown through various departments of the admission service, including the occupational therapy shops, tub rooms, beauty parlor, operating room and the school of nursing classroom.

Dr. R. G. Knapp, a dentist of Utica, was a guest at the hospital on November 2, and was shown some of the work being done here, especially in the line of oral dentistry.

Twenty-seven members of the Women's Auxiliary of St. Ann's Episcopal Church, Sayville, L. I., held their meeting at the hospital on November 14, and were addressed by Dr. A. E. Soper, first assistant physician on "The Story of the State Hospital Patient." Later they visited the occupational therapy sale.

On December 27, Mr. W. Richard Lomax, district representative of the New York State Department of Civil Service, called on the superintendent to discuss various phases of the employment of civil service employees.

A group of Christian Scientists from Manhasset, L. I., came to the hospital on December 28, and entertained about 25 patients who usually attend their services each week. They brought gifts and donations.

Miss Barbara Middendorf, assistant social worker, took a leave of absence to attend certain courses in New York City.

Miss Thelma E. Yochem was appointed instructress of the school of nursing August 1. Mrs. Lucilla M. Zimmerman was appointed assistant principal, October 17.

Miss Eleanore K. Dailey was appointed assistant social worker, August 1.

Miss Marie Louise Franciscus was appointed occupational therapist, August 1.

Miss Theda K. Holmes was appointed voluntary social worker, September 1.

Miss Jean Tait was appointed assistant social worker, October 12.

Two employees died during the six-month period:

James Gilmore, attendant, July 13.

George Boecklin, attendant, November 17.

Rochester

As might be expected, employees of the hospital who were members of the national guard and the reserve corps were called into service; and, up to the end of the year, 10 men of various branches have left the hospital.

Early in November, the annual minstrel show, "The Follies of 1941," was organized by a group of employees. One entertainment was given for the patients in addition to two paid-admission performances. The project was a rather ambitious one but well developed and received with great applause and satisfaction. The employees are to be congratulated in this endeavor.

In November, a suit was brought against the hospital for damages to the extent of $15,000 in the case of a visitor who was pushed over by her sister, a patient, resulting in a fractured hip. The patient was 80 years of age; and the injured sister was in her late seventies and more or less feeble. Because she insisted upon paying attentions to the patient which she did not like, the patient—who was not ordinarily vicious or disturbed—pushed her away; and she fell. After two days in court, Judge Bernard Ryan, of the Court of Claims, dismissed the case on the ground that the plaintiff had not made a valid claim and had not proven negligence in any way on the part of the hospital.

The registration of alien patients, and fingerprinting, was completed without too much difficulty. There were 219 men and 207 women.

Late in December we were informed that this institution would furnish quarters for the representative of the Department of Civil Service who has supervision over zone one. To accommodate this representative and his clerical assistants, the waiting room in the Administration Building was vacated; and equipment has been installed there.

Information seems to have been broadcast to the effect that after January 1, 1941, all employees are to be in the competitive service with the result that the hospital has been flooded with applicants seeking employment. All positions for which there are funds have been filled.

Visits to the Hospital

Visitors to the hospital during the six-month period include: Miss Hester B. Crutcher, director, Bureau of Social Work, July 10 and 11; Mrs. John W. Hotchkiss and Mrs. Theodore Richards, visitors, State Charities Aid Association, July 24; August Witzel, M. D., deputy medical inspector, July 30 and 31.

Assemblymen Abbot Low Moffat and Ennis, Senator Janes and Secretary of Ways and Means Committee, Mr. Locke, re. budget requests, August 15; S. T. Vosburg, supervisnig investigator, Department of Law, August 20 to 21; Charles S. Fareyweather, Division of the Budget, August 21.

Dr. Franz J. Kallman and secretary, Psychiatric Institute and Hospital, September 6 to 10; William J. Tiffany, M. D., commissioner of mental hygiene, September 10 to 11; Major E. B. Garey (At order of General Frank Hines), September 11; Huston K. Spangler, M. D., American College of Surgeons, September 17.

E. D. Camp, Division of Architecture, October 11; Messrs. Robinton and Harrington, Division of Standards and Purchase, October 24.

Kenneth Keill, M. D., acting medical inspector, November 6 to 8; Messrs. P. J. McCormack and Charles P. O'Connell, auditors (unofficial), December 6; Mr. Dutton, Veterans' Administration, Batavia, December 10; and Alex Robinton, Division of Standards and Purchase, December 18.

Rockland

On July 5, a dance and motion picture show were held in the assembly hall to raise funds for the American Red Cross.

On July 8, Dr. T. Bosch, superintendent of Christian Sanitarium, Midland Park, New Jersey, and several other members of his staff visited the hospital to inspect some of the recently constructed buildings.

On July 11, Dr. Victor H. Vogel of the U. S. Public Health Service visited the hosptial in the interest of preventive mental hygiene.

On July 22, Dr. Ralph B. Bush, dental interne, and Dr. Frances M. Hennessey, assistant physician, were married.

Harry E. Winters was appointed pharmacist August 1.

Assemblyman Abbot Low Moffat, chairman of the Ways and Means Committee, Charles T. Locke, secretary of the committee, and Charles Ennis visited the hospital on August 6, made a tour of the buildings and discussed the budgetary needs of the institution.

Miss Ruth Thompson was appointed social worker in the children's group September 9.

Twenty male employees have thus far been inducted into military service.

In the recently published list of hospitals approved by the American College of Surgeons, Rockland State Hospital is included.

Miss Katherine E. Louser, chief dietitian at the Norristown State Hospital, Norristown, Pennsylvania, Mrs. Elva J. Kahrs, chief dietitian of the Founso Infirmary, New Orleans, Lousiana, and Miss Florence Peters of the Department of Welfare, Harrisburg, Pennsylvania, visited the hospital on October 25 to inspect our cafeteria.

Since November 1, Dr. E. R. Rickards, National Health Division, Rockefeller Foundation, has vaccinated 2,291 patients and 450 employees with anti-influenza vaccine.

Dr. E. W. Mullen, superintendent of the Agnew State Hospital, Agnew, California, visited the hospital to inspect our children's group on November 15.

On November 18, Dr. Thomas W. Hagerty, superintendent of Camarillo State Hospital, Camarillo, California, visited and inspected the children's group as he is interested in establishing a similar group at the new Camarillo State Hospital.

A Chickering grand piano for the assembly hall was purchased with funds from the hospital exchange. A thoracoscope and other necessary instruments for thoracic surgery were also purchased with funds from the exchange.

A concert was given in the assembly hall by the British War Relief Society on November 29, to raise funds for relief in England.

The following employees died during the past six-months period:

Anthony McHale, charge attendant, October 6.

James Anderson, policeman, October 7.

Miss Goldie M. Schultz, attendant, September 2.

Miss Charlotte Philcox, attendant, September 20.

James Rourk, barber, December 31.

St. Lawrence

In July, Dr. Milton Jacobs returned from Buffalo where he had taken a course of instruction in the operation of a new anesthetic machine.

On August 5, W. Newton Goold was appointed farm supervisor to succeed James S. Brown, retired.

On August 10, through the courtesy of Colonel Frank K. Ross, commanding officer, Public Relations Division, U. S. First Army, the 26th U. S. Infantry Band gave a concert on the lawn of Curtis Hall.

On August 15, the graduation exercises of the school of nursing were held at Curtis Hall. A class of 27 was graduated. The address was given by John E. White, M. D., Malone, New York.

On August 26, information was received from the Department of Mental Hygiene of the appointment of Mrs. Vanche T. Milligan of Lowville, New York, member of the Board of Visitors, to fill the vacancy caused by the death of Mrs. Virginia A. Spencer.

On September 1, Miss Gladys M. Launderville, R. N., assistant principal, school of nursing, was appointed principal.

On October 10, J. A. Pritchard, M. D., superintendent, was appointed chairman, committee on nursing to succeed Dr. Robert Woodman who retired November 1.

On October 24, the annual masquerade ball was held at Curtis Hall. Approximately 600 patients attended. Music was by Mike Elliott's Orchestra of Potsdam, New York.

On October 31, Mrs. Albert L. Sayer, visitor, State Charities Aid Association, made an official visit to the hospital.

In November, Mrs. Marion Sanger Frank, Ogdensburg, submitted her resignation as a member of the Board of Visitors, to Governor Lehman. Mrs. Frank had been associated with the work of the hospital for 26 years and had been a member of the board for 16 years, and at all times showed a keen interest in the welfare of the hospital and the care and treatment of patients.

On November 25, Harry G. Rainey, M. D., assistant physician, who held the rank of first lieutenant in the medical reserve corps, was called to active duty at Plattsburg Barracks for one year.

On November 29, J. A. Pritchard, M. D., superintendent, received notice of his appointment by Governor Lehman as a member of the Medical Advisory Board, No. 35.

During the summer, bathing parties and picnics for patients were held at the hospital bathing beach; and ward parties and similar entertainments have continued as in the past. At Christmas, each ward had a tree; wards and corridors were attractively decorated; numerous parties were held and seasonal entertainment provided.

Three employees retired during the six-month period:

Brown, James S., farm supervisor, on July 31, after 26 years.

Dilcox, William, blacksmith, after more than 28 years.

Johnston, E. Roy, chauffeur, after more than 35 years.

One employee died during the same period:

George Johnston, gardener, July 18. He had been in the service for 39 years and had been gardener for the past 20 years. He had applied for retirement to become effective July 31.

Utica

The annual field day activities were held on July 9, and because of inclement weather, were conducted in Hutchings Hall. Approximately 700 patients attended; and although the space for races and field events was limited, everyone entered into the spirit of fun and enjoyed the program. A brass band, directed by William Schueler, gave the afternoon color. Light refreshments were served. James E. Simpson, supervisor of physical training, directed the events on the floor, and Mrs. Eleanor C. Slagle, director

of occupational therapy of the Department of Mental Hygiene, was present. Oranges and ice cream were sent to the patients on the wards who were unable to attend.

Miss Eva M. Schied, chief social worker, arranged for an institute for the Utica School for Teacher Training (under charter of St. Joseph's College, Emmitsburg, Maryland), which was held on July 11 in the conference room of the social service department; and 35 nuns were in attendance. The program was: "Child guidance clinics" by Mrs. Norma Russell Terry; "Insulin treatment in mental disease" by Dr. Oswald J. McKendree; and "Hospital social service" by Miss Schied.

Miss Loretta H. Clough, assistant principal of the training school, returned to her studies on July 16, having completed her studies at New York University.

Dr. Victor H. Vogel, representative of the Division of Mental Hygiene, United States Public Health Service, visited the hospital on July 16, to gather information regarding community mental hygiene in New York State for use by the United States Public Health Service, Division of Mental Hygiene, in developing prophylaxis in states backward in mental hygiene.

On July 23 and August 6, Prof. Herbert W. Rogers, director of Lafayette College, Easton, Pa., and 10 students from the New York State College for Teachers, Albany, were here. The lectures were given by Dr. Oswald J. McKendree and by Dr. James N. Palmer, who presented illustrations of various psychoses.

Mrs. Fred M. Goertner of Canajoharie, official visitor of the State Charities Aid Association, visited the hospital on September 5, and attended staff meetings.

Dr. Huston K. Spangler, representative of the American College of Surgeons, Chicago, visited the various departments of the hospital, September 24.

On September 24, the annual meeting of the Oneida County Mental Hygiene Committee was held in Hutchings Hall, in conjunction with the regular meeting of the Utica Council of Social Agencies. The arrangements for this meeting were made by Miss Eva M. Schied as secretary of the Oneida County Mental Hygiene Committee. Dr. Donald W. Cohen, chief child guidance psychiatrist of the Department of Mental Hygiene, presided at the morning session; there were about 60 persons present. Dr. Victor H. Vogel of the United States Public Health Service spoke at the afternoon session, which was attended by 35 physicians. Dinner was served to 120

persons; and about 150 others came to the evening meeting, at which Dr. Milledge L. Bonham, Jr., presided and Dr. Vogel addressed the group on "Looking Ahead in Mental Hygiene."

Graduation exercises were held in Hutchings Hall on September 26, in conjunction with the other hospitals affiliated in the Central School of Nursing—the Faxton and Memorial Hospitals of Utica. Dean Carl Kallgren of Colgate University gave the address, and the respective principals gave the diplomas to the graduates. There were three graduates from this hospital.

On October 15, Prof. Roy W. Foley and 50 students of Colgate University came to the hospital; and a clinical demonstration and lecture were given by Dr. Oswald J. McKendree, acting clinical director, and Dr. James N. Palmer, assistant physician. Dr. McKendree also gave a similar demonstration and lecture to a group of 80 students from the Syracuse North High School and a group of 10 students from Hartwick College on October 30.

Dr. James H. Lade, representative of the State Department of Health, visited the hospital on October 16, in anticipation of obtaining blood specimens to submit to the Department of Health in Albany and to the Johns Hopkins Hospital in Baltimore. The purpose is to check the State laboratory Wassermann examinations with results obtained in the other laboratory.

In December, office space was provided at the hospital for the field representative for Zone II of the Department of Civil Service. This representative will handle the certification of eligibles for "hospital attendant" in this zone, which includes seven institutions.

One employee died during the six-month period:

Fred W. Hersey, master mechanic, September 25.

Willard

Notification was received that Mrs. Edith A. Ellis, appointed a member of the Board of Visitors in April, 1940, died on July 21.

The Neuron Club met at the hospital on August 10.

In August and September, picnics were held on the grounds for the working patients.

Weekly meetings of the Journal Club are held, to which members of the staff contribute papers; addresses have also been given by Dr. Franz Kallmann of the Psychiatric Institute, Dr. Kenneth Slaght of the Rochester State Hospital, Dr. Eugene Davidoff of the Syracuse Psychopathic Hospital and Dr. Robert E. Doran of Geneva.

The Seneca County Medcial Society held its annual meeting at the hospital on October 10.

The graduating exercises of the school of nursing were held at the hospital on November 7; Dr. J. Hillis Miller, president of Keuka College, delivered the principal address.

Psychiatric Institute and Hospital

In cooperation with Columbia University, post-graduate courses in neurology and psychiatry were given at the Institute for a 10-week period beginning October 7 and ending December 13. Seventeen of the institutions in the Department of Mental Hygiene were represented by physicians selected by the individual superintendents.

On December 18 and 19, the American Board of Psychiatry and Neurology held its examinations at the Institute. Most of the members of the staff of the Institute were appointed examiners.

On December 21, the quarterly conference of the State Department of Mental Hygiene was held at the Institute. The scientific program included a review of the research activities of the Psychiatric Institute during the past year, by Dr. Lewis, and a paper on electric shock therapy in mental diseases by Drs. S. E. Barrera and Lothar Kalinowsky, as well as a paper by Drs. Cheney, Hamilton and Heaver of the New York Hospital on "Metrazol as an Adjunct in the Treatment of Mental Disorders."

Syracuse Psychopathic Hospital

Dr. Huston Kiefer Spangler, representative of the American College of Surgeons, visited the hospital on September 20.

On October 24 and December 11 and 12, Dr. Steckel, as chairman of the Committee on Military Mobilization of the American Psychiatric Association, attended a meeting of the Selective Service System Committee at Washington, D. C.

The Hutchings Psychiatric (undergraduate) Society met at the director's home in October and at the hospital in December.

In December, Dr. Steckel attended the quarterly conference of superintendents at the Psychiatric Institute and Hospital in New York City and also a meeting of the Council of the American Psychiatric Association, at which time he, as chairman, presented a report covering the activities of the military mobilization committee of that association.

STATE INSTITUTIONS

Letchworth Village

The Rockland County Medical Society met at Letchworth Village on the afternoon of October 2, 1940. The guest speaker was Dr. Eli Jefferson Browder, professor of clinical surgery in Long Island College of Medicine, Brooklyn. His topic was "Head Injuries."

On October 7, 1940, 360 children of the Roman Catholic faith were confirmed by Bishop Stephen J. Donohue of New York City. The confirmation ceremonies were in Stewart Hall and were attended by many visiting priests, employees of the institution, and parents of the children.

The employees of the institution have contributed generously to the Boy Scout and Red Cross drives.

Newark State School

The number of patients in family care increased from 146 to 189 during the past six months.

A band concert in the afternoon and a display of fireworks were given for the boys and girls of the school on July 4.

The board of supervisors, the judge, the commissioner of public welfare, and other workers in the Niagara County Welfare Department, Lockport, N. Y., visited the school on July 9.

Dr. Thomas Jelley, senior dentist, received a week's leave of absence, beginning July 22, to take a course in child dentistry, sponsored by the Department of Health at the Rochester Dental Dispensary.

Abbott Low Moffat of New York City, chairman of the State Assembly Ways and Means Committee, visited the school August 16. He was accompanied by Messrs. Locke and Ennis, together with Senator Henry Griffith of Palmyra and Arthur N. Christy of Newark, N. Y.

Dr. Ralph Fitch, Rochester, made his first visit as consultant in the physiotherapy department September 13. He examined several of the children and expects to see all who need treatment.

Miss Dorothy A. Pollock, Mrs. Emma Utter and A. J. Bradley, of the occupational therapy department, attended the Twenty-fourth Annual Convention of the American Occupational Therapy Association, in Boston, September 15 to 20. Miss Pollock, also attended the meeting of the House of Delegates as alternate of the Western New York Occupational Therapy Association.

The Neuron Club, a society of psychiatrists and neurologists in the western part of the State, met at the school October 5.

Dr. A. E. Witzel, superintendent, and Dr. H. G. Hubbell, clinical director, were appointed local registrars for selective service of patients falling within the conscription age group.

Dr. Hubbell and E. D. Pritchard, steward, were designated as the new committee to receive data from employees relative to grievances, complaints, etc.

Three of the attendants, who had enlisted in the national guard, were called to service on October 15.

The 4-H Clubs and their leaders attended the Palmyra Fair on September 27, and held their achievement night on November 6, at which time, 27 awards of excellence, three awards of good, and three honorable mentions, were presented for work demonstrated at the fair.

On November 30, through the courtesy of the Montgomery Ward Store in Newark, Santa Claus entertained about 300 children at the school and gave lollypops, sticks of candy and books to each.

Boy Scout Troop No. 147 at the school held its Court of Honor on December 6. Eighteen boys were received into the troop as tenderfoot scouts; five boys received second class awards; four received merit badges; and one received the star award. Edmond Hesser, Wayne County Boy Scout executive, presented a plaque to the troop for winning first place at the Boy Scout Rally in Marion, N. Y., October 14, 1939. Troop No. 147 scored a total of more points in all contests than any other troop represented.

The Cub charter was presented September 28 at the Pack meeting at Camp Hubbell. Twenty-three cubs were registered as Pack No. 147.

On December 9 and 10, the boys and girls of the school presented a play, "A Joke on Santa Claus."

Thirty girls and 10 boys of the school were fingerprinted as aliens by the post office authorities on December 13.

During the morning of December 14, 420 boys and girls of the school were guests of the management of the Capitol Theater and the Merchants' Association of Newark, at a Christmas party at the theater.

Robert Soper was appointed occupational therapist July 1.

Francis Dedrick, who was occupational therapist the past seven years, resigned July 15, to accept a position at the Elmira State Reformatory.

The following employees retired from the service of the school during the past six-months period:

Margaret Ringwood, laundress, June 30.

Helen Hinchman, teacher, August 31.

Isaac DeLizery, special attendant, outside police, December 31.

Syracuse State School

Mrs. Bertram A. Redington of the State Charities Aid Association visited the school on July 18.

Through the courtesy of the Rev. Edmund D. Berrigan, chaplain, arrangements were made with the management of the Syracuse Chiefs for all of the boys at our colonies to attend at least one game at the Municipal Stadium. Two groups of boys from the boys' building also attended the games.

All boys at the colonies attended the State Fair; also, the parole and colony girls.

A WPA dance band concert was given for the girls in Music Hall on the afternoon of July 29; and a similar concert was given on August 16.

An entertainment was given by a group from Wilson playground for our girls, Saturday, August 3.

Two hundred and twenty-nine girls were taken to Suburban Park on September 5 for a picnic. They enjoyed the various concessions at the park. In the group were working girls from our laundry, kitchens, etc.

October 7, Judge Victor B. Wylegala, accompanied by Mrs. Wylegala, while on the way to the conference of Children's Court Judges at Utica spent the afternoon at the school. He is judge of the Children's Court of Erie County.

On October 22 an entertainment for the Jewish children was held in our music hall under the auspices of the Council of Jewish women. Refreshments were served.

The annual Christmas play was given December 18 and 19. About 100 children took part in seven acts depicting episodes in the history of our country from 1776 to 1940.

The annual Elks party was held at Keith's Theater on Friday, December 27, for the children of the city school.

Two employees retired during the six-month period:

Mrs. Bridget F. Donohue, after 27 years of service, July 31.

Miss Mary Riley, laundry overseer, after 27 years of service and following leave of absence due to illness, December 15. Miss Riley died December 26.

Wassaic State School

An impressive flag-raising ceremony was held at the new flagpole on September 18. The band, the Girl Scouts, the Boy Scouts and school children participated.

On September 28, Dr. Raymond G. Wearne, Dr. Ernest S. Steblen, and Dr. Rudolph J. Depner attended the annual meeting of the Northeastern District of the American Association on Mental Deficiency, at Mansfield State Training School, Mansfield Depot, Connecticut.

On October 25, three days before the local Girl Scout drive for funds, Dr. Wearne gave a short talk at Radio Station WKIP, Poughkeepsie, upon the benefits of scouting for girls. Following this, the Wassaic State School Girl Scout Troop concluded the program by singing "America the Beautiful."

Dr. Raymond G. Wearne attended the Thirty-first Annual Meeting of the National Committee for Mental Hygiene at the Roosevelt Hotel, New York City, November 14.

The social service department is concentrating on getting more patients in family care. On July 1 there were 51 patients in homes and at present there are 81. It is hoped to increase this number to 100 in the near future.

Robert J. Bruce, chief engineer, resigned on September 21.

Craig Colony

A clinic was conducted at the colony, July 16, by Dr. Glenn J. Doolittle, clinical director, for the summer students of the Geneseo State Normal School.

Dr. Edward L. Hanes and Dr. G. Kirby Collier of Rochester, visitors for the State Charities Aid Association, paid their annual visit to the colony on September 5.

On July 9, 36 patients belonging to Girl Scout Troop No. 70, at the colony had a day's outing at Canandaigua, N. Y.

The colony patients, Boy Scout Troop No. 70, attended the fireman's parade at Mt. Morris, July 26.

Twenty-eight members of the Four Leaf Clover Club, an organization for adult female patients, had a picnic at Conesus Lake on August 7.

On September 25, the colony's patients, Boy Scout Troop No. 70, held their annual picnic at the Fish Hatcheries at Caledonia, N. Y.

Graduating exercises of the colony's Training School for Nurses were on October 16. There were 14 graduates. The address was given by Dr. A. V. Vickers.

Early in the evening of November 14, a fire caused considerable damage in Iris cottage, occupied by 30 adult female patients.

Dr. Marjorie Bolles, psychologist at the New York Psychiatric Institute and Hospital, spent several days at the colony in December.

CHANGES IN PERSONNEL IN THE MEDICAL SERVICE

Appointments

Assistant Physician

Booth, Dr. H. T., medical interne at Harlem Valley State Hospital, September 15.

Brusca, Dr. Donald D., medical interne at Central Islip State Hospital, September 7.

Dollar, Dr. Helen, (medical interne at Pilgrim State Hospital) at Craig Colony.

Dorey, Dr. John J., medical interne at Utica State Hospital, July 16.

Gralnick, Dr. Alexander, medical interne at Central Islip State Hospital, September 7.

Gritsavage, Dr. Clem E., medical interne at Rockland State Hospital, August 16.

Kaplan, Dr. A. H., medical interne at Rockland State Hospital, August 1.

Lazar, Dr. Martin, medical interne at St. Lawrence State Hospital, September 1.

Lipton, Dr. Edmond, medical interne at Pilgrim State Hospital, July 1.

Mendelson, Dr. Michael, medical interne at Binghamton State Hospital, March 16.

Murray, Dr. William J., medical interne at Binghamton State Hospital, July 16.

Pellens, Dr. Mildred, medical interne at Harlem Valley State Hospital, September 15.

Rainey, Dr. Harry G., medical interne at St. Lawrence State Hospital, September 1.

Rizzolo, Dr. Alfred, medical interne at Harlem Valley State Hospital, September 15.

Roose, Dr. L. J., medical interne at Rockland State Hospital, July 16.

Rosenbaum, Dr. David, medical interne at St. Lawrence State Hospital, July 1.

Vallee, Dr. Clarence A., medical interne at Willard State Hospital, August 16.

Resident Physician

Goodstone, Gerald L., Syracuse Psychopathic Hospital, July 1.

Medical Interne

Bernstein, Dr. Nathaniel, Letchworth Village, September 10.
Broderick, Dr. Thomas C., Central Islip State Hospital, July 1.
Brogan, Dr. John J., Central Islip State Hospital, July 1.
Campbell, Dr. Winona G., Kings Park State Hospital, July 1.
Corcoran, Dr. William A., Binghamton State Hospital, July 8.
Dixon, Dr. Roger W., Gowanda State Homeopathic Hospital, July 15.
Durand, Dr. James F., Brooklyn State Hospital, July 1.
Durgin, Dr. Bernice Elise, Central Islip State Hospital, July 1.
Eggeling, Dr. I. Norwood J., Creedmoor State Hospital, July 16.
Ferber, Dr. David M., Hudson River State Hospital, August 1.
Fraser, Dr. Frank A., Central Islip State Hospital, July 1.
Hemminger, Dr. Violet May, Binghamton State Hospital, July 22.
Horwitz, Dr. David, Rochester State Hospital, September 1.
Howard, Dr. Rhoda, Willard State Hospital, July 2.
Hutchinson, Dr. John J., Central Islip State Hospital, July 1.
Jacoby, Dr. Ralph B., Pilgrim State Hospital, November 11.
Johnston, Dr. George H., Pilgrim State Hospital, July 1.
Kalinowski, Dr. Lothar, Pilgrim State Hospital, October 19.
Kelly, Dr. Francis W., Brooklyn State Hospital, July 1.
Mascali, Dr. Angelo, Harlem Valley State Hospital, September 15.
McLeay, Dr. Mary L., Utica State Hospital, September 6.
Murphy, Dr. James A., Pilgrim State Hospital, July 1.
Pacella, Dr. Emilio R., Pilgrim State Hospital, November 11.
Parker, Dr. Ceylon M., Pilgrim State Hospital, October 1.
Piekielniak, Dr. Theodore W., Utica State Hospital, November 1.
Savitsens, Dr. George W., Creedmoor State Hospital, July 1.
Trapp, Dr. Fritz, Gowanda State Homeopathic Hospital, November 16.
Weiss, Dr. Bernard, Hudson River State Hospital, September 9.
Weiss, Dr. Edward J., Creedmoor State Hospital, July 16.
Wright, Dr. Floyd, Newark State School, July 1.
Wright, Dr. Harold S., Pilgrim State Hospital, July 1.
Zubrod, Dr. Charles G., Central Islip State Hospital, July 1.

Dental Interne

Hayes, Dr. William J., Syracuse State School, September 1.

O'Connell, Dr. Raymond, Brooklyn State Hospital, September 9.

REINSTATEMENTS

Holb, Dr. Mary, senior assistant physician, (returned from sick leave), Pilgrim State Hospital, November 1.

Gray, Nelson M., medical interne, Creedmoor State Hospital, July 10.

PROMOTIONS

Superintendent

Lang, Dr. H. Beckett, from director of clinical psychiatry, Pilgrim State Hospital and acting medical inspector, to superintendent, Buffalo State Hospital, July 1.

Schmitz, Dr. Walter A., from clinical director Middletown State Homeopathic Hospital, to superintendent, Middletown State Homeopathic Hospital.

Witzel, Dr. August E., from first assistant physician, Brooklyn State Hospital and acting medical inspector, to superintendent, Newark State School, October 1.

Acting Medical Inspector

Keill, Dr. Kenneth, first assistant physician, Pilgrim State Hospital, October 15.

Senior Dentist

Jelley, Dr. Thomas, Newark State School, July 1.

ON LEAVE OF ABSENCE

Brill, Dr. Loretta, assistant physician, Pilgrim State Hospital, on sick leave, November 1.

Maxwell, Dr. P. Dickinson, medical interne, Pilgrim State Hospital, on sick leave, August 5.

On Military Duty

Brussel, Dr. James A., senior assistant physician, Pilgrim State Hospital, October 29.

Doltolo, Dr. Joseph J., assistant physician, Hudson River State Hospital, October 15.

McGowan, Dr. John F., assistant physician, Buffalo State Hospital.

Niles, Dr. Charles E., senior assistant physician, Hudson River State Hospital, September 16.

Parson, Dr. Donald W., dental interne, Pilgrim State Hospital, December 3.

Rainey, Dr. Harry G., assistant physician, St. Lawrence State Hospital, November 25.

Schutkeker, Dr. Bruno G., senior assistant physician, Buffalo State Hospital.

Taylor, Dr. Charles W., assistant physician, Kings Park State Hospital.

Wittson, Dr. Cecil L., senior assistant physician, Central Islip State Hospital, (in naval service).

Transfers

Bigelow, Dr. Newton J. T., director of clinical psychiatry, from Utica State Hospital to Pilgrim State Hospital, September 1.

Lehrman, Dr. Samuel R., assistant physician, from Utica State Hospital to Creedmoor State Hospital, July 16.

Luidens, Dr. Henry, assistant physician, from Rochester State Hospital to Auburn Prison, October 1.

McGreevy, Dr. Joan F., assistant physician, from Newark State School to Willard State Hospital, July 15.

Schneider, Dr. Paul M., assistant physician, from Pilgrim State Hospital to Rochester State Hospital.

Retirements

Matthews, Dr. A. C., first assistant physician, Kings Park State Hospital, after more than 24 years of service, December 1.

Woodman, Dr. Robert, superintendent, Middletown State Homeopathic Hospital, November 1.

Resignations

Senior Assistant Physician

Gaulocher, Dr. Archibald, Harlem Valley State Hospital, December 19. (To take appointment in U. S. Department of Health.)

Assistant Physician

Fitzgerald, Dr. Gerald, Kings Park State Hospital, September 21.

Harrison, Dr. William C., Gowanda State Homeopathic Hospital, August 15.

Lavin, Dr. Paul R., Central Islip State Hospital, July 31.

Lynch, Dr. A. Dorothea, St. Lawrence State Hospital, November 30.

Sherman, Dr. Charles S., Gowanda State Homeopathic Hospital, November 23.

Sisserson, Dr. Barney, Pilgrim State Hospital, October 7.

Medical Interne

Anderson, Dr. James O., Pilgrim State Hospital, October 1.

Blade, Dr. Werner, Kings Park State Hospital, July 20.

Cole, Dr. Lewis F., Utica State Hospital, October 31.

Green, Dr. William F., Creedmoor State Hospital, July 8.

Hager, Dr. Dorothy, Central Islip State Hospital, September 10.

Hemminger, Dr. Violet May, Binghamton State Hospital, September 21.

Kuntz, Dr. Julius A., Letchworth Village, November 27.

Mosco, Dr. James A., St. Lawrence State Hospital, August 12.

Murphy, Dr. James A., Pilgrim State Hospital, November 30.

Rudmin, Dr. Joseph, Pilgrim State Hospital, July 31.

Watson, Dr. Hugh A., Creedmoor State Hospital, October 21.

Dental Interne

Hayes, Dr. William F., Harlem Valley State Hospital (to enter military service), November 4.

Sullivan, Dr. John J., Syracuse State School, June 30.

Death

Rowland, Dr. Edward A., senior assistant physician, Manhattan State Hospital, July 10.

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Creedmoor

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ADDRESSES, LECTURES AND SPECIAL EDUCATIONAL ACTIVITIES

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O'Neill, Francis J.: Myasthenia gravis with a case presentation. Before Binghamton Psychiatric Society, November 25.

Pooler, Harold A.: The child at home and at school. Before parent-teacher group, Daniel Dickinson School, Binghamton, November 19.

Snow, Herman B.: A report on the treatment of schizophrenia with insulin and metrazol covering a three-year period. Before the Binghamton Psychiatric Society, October 28.

Elliott, Helen E.: Sex education and mental hygiene. Talk to parent-teacher group, Longfellow School, Binghamton, November 7, and to parent-teacher group, Abraham Lincoln School, November 19.

Résumé of the gynecological service during the past year. Before Binghamton Psychiatric Society, November 25.

Brooklyn

Bellinger, Clarence H.: The insane, their recognition and treatment. Address at meeting of Arts and Sciences, Academy of Music, Brooklyn, November 6.

Lecture and clinical demonstration to students in abnormal psychology from New York University, December 13.

Beckenstein, Nathan: Lectures and clinical demonstrations to the following groups:

Reconciliation Trips, Inc., July 13.

Graduate students in psychopathology from the College of the City of New York, November 2 and 30.

Reconciliation Trips, Inc., November 16.

Students in adolescent psychology from the College of the City of New York, December 14.

Riemer, Morris D.: Presentation of cases of the major psychoses to a group from Lafayette High School, November 2.

Child psychiatry. Address at meeting of parent-teachers association, P. S. 244, Brooklyn, November 20.

Problems in mental hygiene. Talk to senior nurse group from New Jersey State Teachers College, December 9.

Bianchi, John A.: Problems in the treatment of mental illness. Address before the Newman Club of Long Island College of Medicine, November 12.

Nelson, Julius L.: Lecture and clinical demonstration to German-Jewish Club, New York, September 21.

Sex education for the adolescent. Address at meeting of parent-teachers association, P. S. 252, Brooklyn, December 4.

Adolescence, its problems and guidance. Address at meeting of parent-teachers association, P. S. 149, Brooklyn, December 18.

Zeifert, Mark: Lecture and clinical demonstration to class in abnormal psychology, from New York University, July 12.

The organic psychoses. To a group of nurses from the New York State Psychiatric Institute, December 12.

Train, George J.: Behavior problems in children. Talk at meeting of parent-teachers association, Junior High School, No. 252, Brooklyn, November 12.

Problems of mental hygiene. Address at Midwood Temple, December 6.

General problems of the child. Talk at meeting of parent-teachers association, at P. S. 219, Brooklyn, December 11.

McGowan, John E.: How to form good habits in children. Address at meeting of Red Hook Community Center, Brooklyn, July 17.

Unwin, Florance R.: Thirteen two-hour lectures in home nursing and hygiene to a group at the Brooklyn Chapter of the American Red Cross, from September to December.

Lockwood, Mildred H.: Lectures to student nurses at Brooklyn State Hospital during October on the following subjects: Mental hygiene and drugs; education and recreation; agencies, methods for relief and prevention.

Porter, Victorine H.: Lectures to student and affiliate nurses at Brooklyn State Hospital during October and November on the following subjects: Development of the modern attitude toward social problems; delinquency and crime; alcohol and the toxic psychoses; history of social work.

Buffalo

Abrahamer, H. W.: Man and his mind. To Trinity Lutheran Church, October 3.

Central Islip

McLaughlin, Dorothy D.: Professional problems. Address as president of the Nurses Association of the Counties of Long Island, given at St. Catherine's Hospital, Brooklyn, October 30.

Practical management of the psychiatric problem. As chairman of the committee participated in planning the program and presided at the meeting when it was presented to the members of the New York City League of Nursing Education, Psychiatric Institute and Hospital, New York City, November 6.

The rôle of the nurse in the mental hygiene program. Address as chairman of the Committee on Mental Hygiene and Psychiatric Nursing of the New York City League of Nursing Education at the alumnae meeting of Brooklyn Hospital, December 3.

Creedmoor

Buckman, Charles: Talk on general admission and treatment of patients. To a group of students from Adelphi College, Garden City, August 2.

Glasser, Frank B.: Lecture on methods of admission to a New York State Hospital, including mental defectives and epileptics. To a group of about 60 at Red Cross Headquarters, Jamaica, November 4.

Hall, Robert J.: Talk on use and benefits of continuous-flow baths. To a group of students from Adelphi College, Garden City, August 8.

Talk on family relationships and mental health to a group of girl students of Flushing High School, December 2.

Demonstration and lecture to psychology class of Queens College at Creedmoor, December 16.

Gray, Nelson M.: Lecture with clinical demonstration of cases. To a group of students from Adelphi College, Garden City, August 2.

GOWANDA

Gray, E. V.: Psychology in the management of men. Talk before Southwestern New York Reserve Officers' Association, October 29.

Mental hygiene. Talk before the South Buffalo Kiwanis Club, December 9.

Bohn, R. W.: The problem of mental illness. Talk before members of Summer Training School for Lutheran Sunday School Teachers, July 27.

Marritt, H. D.: The development of mental hygiene clinics in the community. Talk before sociology class of Salamanca High School, October 23.

Prevention of mental illness. Talk before Ripley Health Service, November 18.

Psychiatric problems in the school. Talk before Chautauqua and Cattaraugus Counties Guidance Association, Brocton Central School, December 7.

Tomlinson, Paul J.: Modified insulin therapy. Talk before Buffalo Neuropsychiatric Society, September 7.

Ozarin, Lucy D.: Involution melancholia complicated by pituitary cachexia. Paper read before Buffalo Neuro-psychiatric Society, on September 7.

Hudson River

Kelleher, James P.: Mental illness with demonstration of clinical types. Lecture at hospital to a group of students from the department of economics and sociology, Vassar College, Poughkeepsie, October 28.

Lecture on different forms of mental illness given to a group of teachers, nurses and social workers enrolled at New York University, December 18.

Notkin, John Y.: Endocrine treatment of dementia præcox and of involution melancholia. Lecture given during the interdepartmental course in endocrinology at the New York Post-Graduate Medical School, Columbia University, October 11.

Wolfson, Leo: Clinical demonstrations of various types of mental disease. To a class in abnormal psychology from Bard College, October 31 and November 28.

Kings Park

Steen, Reginald R.: The problem of the mentally ill. Talk and presentation of case before the Huntington Discussion Group at Kings Park State Hospital, October 7.

Anderson, Lloyd: Choosing one's life work. Talk before students of Northport High School, October 23.

Our America. Talk before students of Kings Park State Hospital, November 8.

Steen, Patricia: Mental hygiene for the foster child. Talk to Foster Parents, Suffolk County, under the auspices of the Board of Child Welfare, at Islip, November 1.

Lecture on psychiatry. To post graduate nurses, Huntington Hospital, Huntington, November 25 and December 9.

Relation between community and mental hospitals. Talk to Mental Hygiene Committee of Nassau County, at Kings Park State Hospital, December 10.

MANHATTAN

Phillips, Arthur M.: Lectured with clinical demonstrations of psychiatric cases to a group of students of Columbia University three times weekly, July 1 to August 15.

Lectured with clinical demonstrations of psychiatric cases to a group of second year students of Cornell University Medical School once weekly beginning in December.

Bloomfield, Maxwell I.: Lectured with clinical demonstrations of functional and organic psychoses to a group of students of the College of the City of New York, August 8 and 15.

Lectured with clinical demonstrations of the functional and organic psychoses to a group of students of the Department of Psychology, College of the City of New York, December 27.

Hoch, Paul: Lectured with clinical demonstrations of the organic psychoses to a group of students of New York University, Department of Educational Psychology, July 29.

Lectured with clinical demonstrations of psychiatric cases to a group of students of New York University, Department of Educational Psychology, August 2 and 5.

Lectured with clinical demonstrations of psychiatric cases to a group of students of Hunter College, August 15.

Lectured on electric shock therapy in mental disorders to the New York Physical Therapy Society at the Academy of Medicine, December 4.

Psychogalvanic investigation in psychoses. Paper in collaboration with Joseph F. Kubis, and F. Rouke. Read at the meeting of the Psychiatrical Society of the Metropolitan State Hospitals, October 21.

Gioscia, Nicolai: Lectured with clinical demonstrations of the functional psychoses to a group of students of the College of the City of New York, November 25.

Discussed the sociological aspects of psychiatric cases in the community with demonstration of cases to a group of students of the College of the City of New York, December 14.

MARCY

Bisgrove, Sidney W.: Etiology of mental diseases. Talk before a group of Georgetown Central high school students in charge of the Rev. Joseph Chapman, director of religious education, November 28.

Black, Neil D.: Clinic for 20 members of the Social Workers' Club of Warren County and city of Glens Falls, at hospital, October 28.

Hutchings, Charles W.: Modern methods of treatment of mental diseases. Radio talk over WIBX, October 28.

Gronlund, Anna A.: Mental hygiene in childhood. Talk before the parent-teacher association of Sauquoit central school, November 4.

Primary behavior disorders and reading disabilities. Talk before the parent-teacher association, Munnsville, November 11.

Emotional development of the boy and girl. Talk before the Rome parent-teacher study group at the Women's Club, Rome, N. Y., December 4.

The child guidance program of Madison County. Talk to Madison County Children's Committee, December 6.

Bryan, L. Laramour: Insulin and metrazol treatment. Lecture to Social Workers' Club of Warren County and city of Glens Falls, on a visit to the hospital, October 28.

MIDDLETOWN

Kelly, William E.: Bureaucratic medicine. Talk before Rotary Club of Port Jervis, N. Y., July 3.

Selleck, Edith G.: Mental hygiene in the community. Talk before Rotary Club of Port Jervis, N. Y., June 5.

Mental hygiene in the community. Talk at Community Club luncheon, Port Jervis, N. Y., September 26.

Sporn, Abram J.: Physical changes during puberty and problems incidental to them, and mental development of the adolescent. Talk before Adolescent Child Study Group of the Liberty Street School Parent-Teacher Association, December 16.

Moody, Ray W.: The problem of dementia præcox. Address to Lions Club, Middletown, N. Y., October 9.

PILGRIM

Bigelow, Newton J. T.: Harmless home rule. Address to Parent-Teacher Association, Whitesboro, November 13.

Brussel, James A.: Organization, supply and personnel of the medical unit at Fort Dix during summer training. Address to the 302nd Medical Regiment and enlisted personnel, New York City, October 1.

Barwise, Constance: Child guidance clinic. Address before the Business Woman's Club of Freeport, September 26.

The challenge of parenthood. Address to the West Islip Parent-Teacher Association, November 7.

Kalinowsky, Lothar: Lecture on electric shock therapy at eighth annual lecture series of the Neuropsychiatric Institute of the Hartford Retreat, Hartford, Conn., December 4.

Paper (with S. E. Barrera and William A. Horwitz of the Psychiatric Institute), read before the quarterly conference at the Psychiatric Institute, December 21.

Harris, Mary Ann: Lecture and demonstration of psychological testing to supervising nurses at the hospital, September 6.

ROCHESTER

Van De Mark, John L.: State institutions and the mental hygiene problem. Talk before Arnett Branch of Y. M. C. A., Rochester, November 18.

Slaght, Kenneth K.: Lectures on clinical psychiatry—third year medical students, University of Rochester Medical School.

Lecture and clinical demonstration. Nurses' Training School, Craig Colony, Sonyea, N. Y.

Lecture and clinical demonstration, student body Colgate-Rochester Divinity School and Extension Class in Abnormal Psychology, University of Rochester.

The ministry and mental hygiene. Conference of Methodist Ministers, Y. M. C. A., Rochester.

The minister's need for clinical training. Regional Conference of the Council for Clinical Training of Theological Students, Rochester-Colgate Divinity School.

Factors that weigh mental health. Lecture Brick Church Institute, December 4.

How our respective professions supplement each other. Conference on Pastoral Ministry, Colgate-Rochester Divinity School, October 8.

English, William H.: The form and function of the central nervous system. Lecture and demonstration to class in developmental psychology, University of Rochester, November 12.

Lemmle, Malwina T.: Current methods of caring for mental illness. Psychology Department, Lake Erie College, Painesville, Ohio, November 30.

Modern trends in the treatment of mental illness. Faculties of Public Schools 7, 30, 34, 40, 41, Rochester, December 3.

ROCKLAND

Smith, James W.: Member of board of visitors, lecture course at the American Academy of Ophthalmology Convention in Cleveland, week of October 7.

Miller, Joseph F.: Positive and negative aspects of parental authority; or guiding the child toward normal human relations. Talk to the Nanuet Mothers' Club, Nanuet, New York, October 15.

The history of psychology and of human behavior. Talk to the Pearl River High School Alumni Association, Pearl River, New York, November 19.

Symbols in normal and abnormal behavior. Address before the Jewish Men's Club at the Community Center in Spring Valley, New York, November 26.

Munn, Charlotte: The physical and mental development of the normal child; everyday problems of the normal child; the psychology of adolescence; experiences of adolescence; the emotional experiences of adolescence; the psychological approach to sexual education of children. Series of lectures given at Public School No. 13, Yonkers, New York, October 2, October 14, October 21, October 28, November 18 and November 25.

The importance of emotional, social and religious balance; the moral and religious development of the child; the psychology of religion; the assets of religion; the liabilities of religion; why we behave as we do. Series of lectures at the School of Religion, Christ Church, Suffern, New York, October 14, 21, 28, November 4, 11 and 18.

Smith, Percy L.: Alcoholics and psychiatry. Address before the Alcoholic Anonymous Club, New York City, July 30.

Clardy, Ed Rucker: Emotional or adjustment problems of the school child. Address before the parent-teacher association, Pearl River High School, October 18.

St. Lawrence

Berman, Harold H., and Carson, William R.: Lecture and clinical demonstration on organic and functional psychoses, to summer school students of Potsdam Normal School, under the leadership of Professor John W. Maxcy, health director, at the hospital, July 25.

Lecture on the psychology of mental diseases and clinical demonstration on functional and organic psychoses. To 60 students of Professor D. E. Buzby's class in abnormal psychology, St. Lawrence University, at the hospital, December 12.

Brown, James E.: Mental health. Talk to the Jefferson County Home Bureau, Jefferson County Tuberculosis Sanatarium, Watertown, November 26.

The administration of some of the newer drugs. Talk to the Nurses' Alumni Association, St. Lawrence State Hospital, October 1.

Carson, William R.: See Berman, Harold H.

Ellsworth, Clara E.: Psychiatric social work. Talk to the study group of St. Lawrence County at Canton, July 1.

UTICA

Merriman, Willis E.: The service of the State hospital to the community. Radio address over Station WIBX, Utica, July 29.

Gosline, Anna J.: Psychological preparedness. Address to the New York State Nurses' Association, District No. 10, Ellis Hospital, Schenectady, November 11.

Clogher, Ralph E.: Dental health. Radio address over Station WIBX, Utica, September 1.

Kirkpatrick, Mabel: Mental hygiene resources in the community. Address to members of the Fulton County Department of Public Welfare, Gloversville, July 24.

Can mental hygiene work in a democracy? Address to the Business and Professional Women's Club, Johnstown, November 13.

WILLARD

Kilpatrick, O. Arnold: Clinical demonstrations with lectures to class in abnormal psychology of Hobart College on September 18, 20 and 30; October 18.

The adjustment of the child in school. Address to District Teachers' Convention at Interlaken Central School, September 30.

The family physician as a community psychiatrist. Address to the Seneca County Medical Society, October 10.

Common sense in living. Address to Zonta Club, Watkins Glen, November 18.

Clinical demonstration with lecture to class in abnormal psychology from Cornell University, December 12.

Guthiel, George N.: Clinical demonstration with lecture to class in abnormal psychology, from Cornell University, December 10.

Walters, Guy M.: Clinical demonstration with lecture to class in abnormal psychology from Cornell University, August 9 and December 17.

Strong, Willis A.: Clinical demonstration with lecture to student nurses from Auburn City Hospital, October 29.

Osborn, Leslie A.: What constitutes the abnormality. Address to students in mental hygiene from Cornell University, August 6.

SYRACUSE PSYCHOPATHIC

Steckel, Harry A.: A case of paranoid condition. Presented before the Thursday Night (medical) Club, October 3.

Psychiatry in a defense program. Address before the Michigan Society for Mental Hygiene, as chairman of the Military Mobilization Committee of the American Psychiatric Association, at Grand Rapids, Michigan, October 11.

Psychiatric aspects of the national defense program. Address before the annual meeting of the National Committee for Mental Hygiene, New York City, November 14.

Round table discussion—mental hygiene and religion, over Station WSYR, December 28.

Davidoff, Eugene: Psychology of problem children. To students of psychology class of Syracuse University Summer School, at the hospital, July 31.

Mental hygiene implications in obstetrics. To the nurses of Syracuse Memorial Hospital, August 5.

What's on your mind? Talk before the Young People's group of the First Presbyterian Church, Baldwinsville, N. Y., November 5.

Manic-depressive psychoses. Talk before the Journal Club of the Willard State Hospital, November 19.

Need for psychiatric help in marital relations. To Marital Relations Bureau at 101 Scottholm Terrace, Syracuse, December 9.

STATE INSTITUTIONS

LETCHWORTH VILLAGE

Humphreys, Edward J.: The medical diagnosis of mental defect. Read before the Northeastern Section Meeting of the American Association on Mental Deficiency, Mansfield State Training School, Mansfield Depot, Conn., September 28.

Mental deficiency in relation to the field of mental hygiene. Before the Mental Hygiene Club of Hunter College, December 12.

Medical aspects of mental deficiency. Panel discussion at the North Jersey Training School, Totowa, N. J., December 16.

Abel, Theodora M.: Moral judgments among subnormal adolescent girls. Read before the American Psychological Association, Pennsylvania State College, September 6.

Special techniques for measuring dynamic aspects of functioning in the mentally deficient. Panel discussion, American Association for Applied Psychology, Clinical Section, Pennsylvania State College, September 2.

Kinder, Elaine F.: Some results of a systematic attempt to recover memories of psychopathological experiences during a psychosis. Read before the American Psychological Association, Pennsylvania State College, September 4.

Member of a panel discussion on the licensing of psychologists. American Association for Applied Psychology, Clinical Section, Pennsylvania State College, September 3.

McCulloch, Thomas L.: An experimental study of factors influencing memory in mental defectives. Read before the annual meeting of the American Psychological Association, Pennsylvania State College, September 4.

NEWARK STATE SCHOOL

Witzel, A. E.: Misconceptions of mental disease. Address to the Lions Club, Newark, October 9.

Team work. Talk to the Men's Club of the Newark State School, November 13.

Emotions in our work. Talk to the Employees' Association of the Newark State School, December 4.

Series of talks on psychology and mental hygiene to officers and employees of the Newark State School, Monday evening during December.

Hubbell, H. G.: Clinical demonstrations, with lectures:

Before class in psychology of the exceptional child, Geneseo State Normal School, July 24.

Before class in psychology of the University of Rochester, July 24.

Before students of Nazareth College, Rochester, October 22.

Baumgartner, E. A.: Review of autopsies at the Newark State School with special reference to the brains. Address at meeting of Neuron Club at Newark State School, October 5.

Sirkin, Jacob: Treatment of spastic paralysis. Address, illustrated by motion pictures, to the Rotary Club, Wolcott, August 17.

Treatment of cerebral palsy. Address to the meeting of the North Eastern District of the American Association on Mental Deficiency, Mansfield Depot, Conn., September 28.

Pollock, Dorothy A.: Recreational activities of children at the Newark State School, with movies of field days, before the Philathea Class of the First Baptist Church, Newark, December 4.

Syracuse State School

Deren, Solomon D.: Mental hygiene. A six-weeks course to 28 college students, July 1 to August 9.

Psychology of the mentally handicapped. Lecture to students in the Department of Psychology, Syracuse University, July 25.

Reaction types among the mentally defective. Lecture to students in mental hygiene, Syracuse University, August 8.

Nursing care of mentally deficient in health and sickness. Memorial Hospital group, 20 to 25 members. Lecture to student nurses, August 14.

The mentally deficient in health and disease. Memorial Hospital group, November 12.

Social control of the mentally defective. Lecture to students in the Department of Psychology, November 14,15.

Application of mental hygiene principles in a State institution for the mentally defective. Lecture to Dr. Harry A. Steckel's class, November 20.

Education and training of the mentally defective. To the graduate class of the Department of Psychology, December 12.

Feeblemindedness, social, economic and educational aspects. Lecture to a joint session of members of the Psi Chi Club, Syracuse University, December 17.

Wassaic State School

Pense, Arthur W.: Clinical demonstrations with lectures to groups of Harlem Valley State Hospital student nurses, September 17 and December 17.

The mental defective in relation to mental hygiene. Lecture before a class studying mental hygiene in a New York University Extension Course in Poughkeepsie, December 11.

Craig Colony

Doolittle, Glenn J.: Mental hygiene. Talk before Mt. Morris Rotary Club, July 23.

Doolittle, George M.: Convulsive disorders. Address, as retiring president, to Livingston County Medical Society, December 12.

ADMINISTRATIVE OFFICES

Bureau of Statistics

Malzberg, Benjamin: A two-year followup study of dementia præcox patients treated with insulin. Read at Quarterly Conference of State Department of Mental Hygiene, March 23.

A statistical study of results of pharmacological shock therapy in the New York hospitals. In collaboration with Dr. John R. Ross. Read at the annual meeting of the American Psychiatric Association, Cincinnati, Ohio, May 23.

Trends in the growth of population in the schools for mental defectives. Read at annual meeting of American Association on Mental Deficiency, Atlantic City, N. J., May 23.

BOOK REVIEWS

Emotional Hygiene; The Art of Understanding. By CAMILLA M. ANDERSON, A. B., M. D. With an introduction by Ross McC. Chapman, M. D. Cloth, 253 pp. Philadelphia. J. B. Lippincott Company, 1940. Price $2.00.

A second edition of Dr. Anderson's practical textbook will be welcomed. It was primarily designed for use in nursing schools and has had a gratifying reception, but its interest extends beyond the student nurse; and it has been popular with social workers, medical students and others interested in welfare activities. It is written in a pleasing style and in terms that students and others accustomed to scientific books will find understandable. Numerous black and white drawings by Dorothy Stevenson add to the interest and attractiveness of the book.

Its theme may be said to be the development of cooperation and adaptation to life's situations. This plan is carried out by a thorough discussion of the problems of childhood, adolescence, the psychology of the family group, the importance of gradual emancipation from parental authority and the establishment of initiative and independence of thought and determination.

Special short chapters are devoted to topics such as "The Feeling of Security" and "Personal Problems;" and special attention is given to suggestions for successfully dealing with patients in hospitals, adaptation of hospital personnel to each other, to the staff and to the public.

Dr. Anderson has presented a well balanced survey of the field of emotional hygiene, recognizing that both the teacher and the student should view the subject of mental hygiene in its widest aspect; that no one school of psychiatric thought should exclude fair consideration of other views. It is to be regretted that the cloth binding is flashy and unattractive for a volume of this character. The same criticism applies to the dust jacket.

Sex in Marriage. By ERNEST B. GROVES and GLADYS H. GROVES, New York. Emerson Books, Inc., 1940. 250 pages. Price $2.00.

Whether the institution of marriage will survive for long in its present form is a question the cynics are posing with growing insistence. Between Hollywood and Reno it has received hard jolts in recent decades. Public opinion is undoubtedly undergoing a change, if one may judge by the society columns of newspapers and by the example of some of the nation's highest families. Divorce is no longer a family skeleton. More frequently it is just a matter of convenience or whim. To the psychiatrist, a successful marriage indicates sound and mature personality in one or both individuals concerned; and, by the same token, matrimonial failure discloses to him the existence of personality defects in one or both members of the union which make adaptation impossible.

The authors appear to be impressed by the importance and frequence of sexual maladjustment as one of the sources of marital disharmony. The view is shared by many others; and of late years numerous publications, both in book form and in magazine articles, have contributed toward the solution of the problem. Granting as much of this to be true as the proponents would claim, the psychiatrist still would have no occasion to modify his views, for he has in mind the psychiatric dictum that a mature personality has no sexual conflicts.

Here then, one gets a glimpse of a situation in modern life which has to do with social failures. Beside the divorce evil, which is perhaps only a part of the marriage evil, there are ranged the two other outstanding evils, the lunacy evil and the evil of criminality. The psychiatrist sees them as variations of an imperfect psychic organization. Elmer Southard, in his "Kingdom of Evils," recognized this, although the perspective of his day did not encompass the whole situation as clearly as is now possible. When happier marriages are made, they will be made by people who have been trained for marriage from infancy. This is just another way of saying that the origins of marital discord and disharmony are to be found in the earliest experiences of life. Until parents are better prepared by precept and example for parenthood, and until children are reared by parents who are better prepared for parenthood, not much improvement can be hoped for. That is not saying that books like "Sex in Marriage" have not an appropriate place. It is educational in its scope and treatment. The authors have discussed the subject frankly and yet with scholarly reserve. Their views are sound and are expressed in words that the average person would have no difficulty in understanding. It is not a medical book. Like other popular works by these authors, it is addressed to college students and general readers.

The Public Health Nurse and Her Patient. By RUTH GILBERT, R. N., 1940. New York, The Commonwealth Fund. London, Humphrey Milford. Oxford University Press. 396 pages. Price $2.25.

Social workers in state hospitals, as well as public health nurses, will welcome this book and find it a valuable aid in giving insight to the psychiatric approach used in dealing with the individual patient, with groups of patients and with co-workers. It deals primarily with attitudes and relationships of the nurse and the patient in the reality situation.

The author, who is a public health nurse as well as a psychiatric social worker, has drawn on her own practical experience to showing that mental hygiene, instead of adding to the duties of the nurse, will simplify her task by giving her an understanding of the reasons for her patients' reactions to situations.

The book contains six chapters:

Chapter 1—Introduction.

Chapter 2—Nursing the Sick Patient, which studies:

(1) The nurse's attitudes toward bedside nursing.
(2) The patient's attiudes toward illness.
(3) Emotional reactions to physical defects and injuries.
(4) Mental defect and disease as seen on the district.

Chapter 3—Teaching Health.

(1) Building a relationship between nurse and patient.
(2) The nurse's relation with the individual patient: some techniques.
(3) The nurse's relation with groups of patients.

Chapter 4—Nurse and Maternity Patient.

Chapter 5—The Child in His Family.

(1) Introduction.
(2) The child grows, matures and learns.
(3) Familiar training situations.
(4) Problem behavior.

Chapter 6—Relationships with Co-Workers.

(1) Relationships between nurses in the same organization.
(2) Interagency relationships.

An extensive bibliography.

Miss Gilbert's discussion is well worth a careful study. It calls the reader's attention to the advisability of stopping to think and of going slowly—with the realization that her reactions to situations may help or hinder her effectiveness with the individual or group.

Borrowed Children. By Mrs. St. Loe Strachey. The Commonwealth Fund, New York, 1940. 149 pp. with appendix. Price 75 cents.

This little volume is a collection of anecdotes, clinical notes and observations on the evacuation of London children to rural Great Britain at the outbreak of war in 1939. It does not pretend to be profound or complete, and its author notes that "it is not intended for the trained psychologist, the trained educationalist, or the practised social reformer;" but that its aim is to give "intelligent, untrained people . . . a picture intimate in its detail of the first months of evacuation and of the unforeseen problems which immediately arose."

The picture necessarily is unprofessional, the arrival of bewildered groups of evacuees, their reception by equally bewildered, untrained hostesses, and the difficult problem of adjustment, with reports of behavior disturbances—enuresis, pilfering, tantrums—which, except for their large-scale occurrence, might be notes from any American child guidance clinic.

Disorganized and sketchy as Mrs. Strachey's book is, it still sets forth a problem which is worth the thoughtful attention of the American psychiatrist and psychiatric social worker. More than 700,000 unaccompanied school children were evacuated from their homes in London and other great British cities at the outbreak of the present war. Five mental health societies had joined in the formation of a national Mental Health Emergency Committee early in 1939; the committee had conducted a registration of all British full-time, salaried social workers in the mental health field; and hasty arrangements had been made to have those workers available in the counties where children were to be evacuated. The aim was to have social workers and psychiatrists available for advice and treatment in all cases of behavior difficulties.

The problem is one which American psychiatrists might well consider. If it is not fantastic to rush armaments for defense, it would not be fantastic to prepare for possible mass evacuation of children from our sea-coast cities. In New York State, the existing child guidance clinics of the Department of Mental Hygiene might provide a foundation for the machinery needed to handle evacuation problems.

NEWS AND COMMENT

CHANGES IN THE DEPARTMENT

H. Beckett Lang, M. B., who was appointed superintendent of the Buffalo State Hospital, July 1, 1940, became assistant commissioner of the New York State Department of Mental Hygiene on January 1. In another important change in the personnel of the department, Robert Woodman, M. D., retired as superintendent of Middletown State Homeopathic Hospital on October 31, 1940, and was succeeded in that position by Walter A. Schmitz, M. D., on December 1, 1940. Clarence H. Pierce, for two years executive director of public assistance in the Erie County department of public welfare, became secretary of the Department of Mental Hygiene on November 4, succeeding Lewis M. Farrington, who died last August. Biographical notes on Dr. Woodman, Dr. Schmitz and Mr. Pierce appeared in the January PSYCHIATRIC QUARTERLY. Biographical notes on Dr. Lang appeared in the PSYCHIATRIC QUARTERLY in July, 1940, and in January, 1941.

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SUFFOLK COUNTY ESTABLISHES DIVISION OF MENTAL HYGIENE

Suffolk County has established a division of mental hygiene in the county department of health. "To the best of our knowledge," says Arthur T. Davis, M. D., Suffolk County commissioner of health, "this is the first such unit established in a local health department."

"This unit," he says, "will assist in the mental problems arising out of physical conditions in families served by the Health Department as well as the Probation Department, the Children's Court, the Department of Public Welfare and the Board of Child Welfare.

"This is intended to supplement but in nowise to replace the clinics carried on by the State Department of Mental Hygiene, which are chiefly devoted to problems in school children and the followup of their own parole cases."

The Suffolk County Board of Supervisors placed $17,525 in the budget last October to provide for the new unit; and it was expected at that time to have it functioning by January 1. The funds are to provide for a personnel of a psychiatrist, a psychologist, two psychiatric social workers and a clerk; and there is provision for transportation and office expense.

PROF. MILLEDGE L. BONHAM DIES

The PSYCHIATRIC QUARTERLY SUPPLEMENT reports with extreme regret the death of Prof. Milledge Louis Bonham, Jr., head of the history department of Hamilton College, on January 22 at the age of 60.

A historian, a writer and a public speaker, Prof. Bonham was an active and invaluable friend of the Department of Mental Hygiene, working closely and earnestly with the staffs of Marcy State Hospital and Utica State Hospital to promote popular understanding and support for the mental hygiene movement.

As chairman since the foundation of the Oneida County Mental Hygiene Committee—except for a year while he was absent from Hamilton on sabbatical leave—Prof. Bonham presided last September at the Oneida County Child Guidance Clinic Day, a report of which (pp. 120 to 132) is a feature of this issue of the SUPPLEMENT. For the last 14 years, he had devoted much time and energy to the mental hygiene cause.

Dr. Bonham was born in Barnwell, S. C., in 1880, and was educated at Furman University, the University of Virginia, the University of London, the University of Paris and Columbia University, from which he received the degree of Ph.D. in 1910.

He taught in the South and in New York City and at Tufts and Simmons colleges and LaSalle University before coming to Hamilton in 1919. He was a veteran of the Spanish-American War and was active in the work of the Student Army Training Corps in the World War. He leaves his wife and a son who is a student at Hamilton.

Dr. Bonham wrote widely on historical subjects, including a volume on "The British Consuls in the Confederacy," and he found time for many civic interests and much public service, besides his work in the field of mental hygiene.

The executive committee of the Oneida County Mental Hygiene Committee drafted the following resolution on his death.

"Milledge Louis Bonham, Jr., distinguished scholar, forceful leader and friend of the afflicted, departed this life on January 22, 1941, in the sixty-first year of his life. He had been the first and only permanent chairman of this committee since it was organized 14 years ago. His genial presence, his ready wit and warm, sympathetic understanding made him an admirable leader and he was untiring in his efforts to further the cause to which this group is dedicated. He loved people and their good will and friendship were accorded him in noteworthy measure among all classes of the community.

"The Oneida County Mental Hygiene Committee voices its profound sorrow and gives expression to a deep sense of loss sustained in his passing. To the bereaved members of his family, it offers its heartfelt sympathy."

NEW COMMISSION BEGINS MENTAL HYGIENE STUDY

Preliminary study of the problem of reducing the rate of growth of population of the State institutions under the Department of Mental Hygiene has been started by the informal commission appointed by Governor Lehman and headed by Homer Folks.

Newer methods of treatment which might shorten hospital stay, reduction of admissions by greater control of syphilis, earlier parole in suitable cases and expansion of family care are among the subjects which have had preliminary consideration; and subcommittees are to make studies of them.

Present and former officials of the Department of Mental Hygiene on the commission include: Commissioner William J. Tiffany, M. D., former Commissioner Frederick W. Parsons, M. D., Nolan D. C. Lewis, M. D., director of the New York State Psychiatric Institute and Hospital; Clarence O. Cheney, M. D., former director of the Psychiatric Institute and present medical director of New York Hospital, Westchester Division; Miss Hester B. Crutcher, director of psychiatric social work for the department; and Dr. William L. Russell, former medical inspector for the department and former medical director of New York Hospital, Westchester Division.

Other members of the commission are: Dr. Karl M. Bowman, Stanley P. Davies, Dr. Lawrence Kolb, and Dr. George S. Stevenson.

The commission is acting in cooperation with the State Department of Mental Hygiene in making the study. All 11 members were present at its first meeting, December 6, at 105 East 22d. Street, New York City.

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DEATH OF H. DOUGLAS SINGER, M. D.

The PSYCHIATRIC QUARTERLY SUPPLEMENT notes with deep regret the death on August 28, 1940, following an automobile accident in New Mexico, of Dr. H. Douglas Singer, who was president-elect of the American Psychiatric Association, president of the American Neurological Association and chief editor of "The Archives of Neurology and Psychiatry."

Dr. Singer was born and brought up in London and received his medical education there. He came to this country in 1904 at the age of 29 and advanced rapidly to the fore in his profession. He died at the most active period of his career. Extensive biographical notes on Dr. Singer appear in the January "Archives of Neurology and Psychiatry," the January "Journal of Nervous and Mental Disease" and the January "Mental Hygiene."

DR. CHENEY TAKES NEW C. A. A. POST

Dr. Clarence O. Cheney, former director of the New York State Psychiatric Institute and Hospital and at present medical director of New York Hospital, Westchester Division, has been appointed chairman of the New York State Committee on Mental Hygiene of the State Charities Aid Association by Winthrop W. Aldrich, president of the association. He succeeds Dr. William L. Russell, whose resignation was accepted on December 1.

Dr. Russell, also formerly with the State Department of Mental Hygiene, is consulting psychiatrist at the Payne Whitney Psychiatric Clinic of the New York Hospital. Dr. Russell served as vice-chairman of the committee for 25 years and as chairman for five. "Our debt to Dr. Russell is very great," Homer Folks, secretary of the State association, said on his retirement.

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PSYCHIATRY WEEDS OUT MENTALLY UNFIT IN DRAFT

Application of psychiatric principles to weed out the mentally unfit for military service is employed under the present conscription setup. In announcements sent out by national headquarters of the Selective Service System to draft officials and medical aids, it is pointed out that, "In the World War, a great many men who were inducted into the Army were not capable of meeting service conditions . . . It is obvious that men who are feebleminded or are suffering from a gross mental ailment do not make good soldiers."

Medical Circular No. 1, accompanying this announcement, sets forth "A minimum psychiatric examination of registrants" which was prepared as a patriotic contribution by the William Alanson White Psychiatric Foundation. It lists, for the benefit of examining physicians who are not psychiatrists, symptoms of the more common mental disorders and an examination routine for the detection of those disorders among persons who have managed to adjust fairly satisfactorily to civilian life, but who would not be able to stand the strain of military life with its "regimentation, close contact with other persons, separation from their families and inability to escape without fear of grave penalties."

DR. WILLIAM BROWNING DIES AT 85

Dr. William Browning, long outstanding in the neurological field, died on January 5 in Brooklyn at the age of 85.

He had been active in Brooklyn medical circles for 50 years; and Brooklyn State Hospital is included among the important institutions at which he had been attending or consulting neurologist.

Dr. Browning was graduated from Sheffield Scientic School at Yale in 1876, received a diploma in anatomy from the University of Pennsylvania in 1878, studied at the Universities of Wurzburg and Leipzig and received his medical degree from Leipzig in 1881. He joined the faculty of the Long Island College of Medicine in 1887 and was retired as professor-emeritus of neuropsychiatry in 1926.

Dr. Browning's medical works included: "The Veins of the Brain and Its Envelopes," "The Epileptic Interval," "Circulation in the Central Nervous System," "The Thymus and Stammering" and "Medical Heredity." He was a former editor of "Neurographs."

Dr. Browning was active in medical society and civic association circles. His relations with the Department of Mental Hygiene were close and friendly, and his death will be felt as a loss by many friends and colleagues in the department.

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FREUD MEMORIAL ROOM OPENS

An event of outstanding importance in psychiatric circles took place on January 18, 1941, when the Freud Memorial Room was opened at the library of the New York State Psychiatric Institute and Hospital. An informal tea was given to mark the occasion.

The Institute was able to obtain and bring from London part of Sigmund Freud's personal library, 814 items, including books, monographs and pamphlets. Dr. A. A. Brill gave special equipment for the furnishing of the Freudian Room, thus assuring permanent preservation of the collection.

The Psychiatric Institute hopes to have, in time, a complete psychoanalytic library and welcomes contributions by individuals of books or other data which they may wish to have kept in a place of permanent security. Historians, research workers and students of psychiatry have the use of the Freudian collection.

DEATH OF DR. WALTER J. WELLINGTON

Dr. Walter James Wellington, director and physician in charge of Dr. Wellington's House in Rye, a private sanatorium for the treatment of mental disorders, died on November 29. He had been a semi-invalid since 1937, because of a cerebral hemorrhage.

Dr. Wellington, born in Brooklyn, was graduated in 1896 from the Long Island College of Medicine, the president and youngest member of his class, after having completed the four-year medical course in three years. He studied psychiatry in Europe and later was associated with private sanatoria in the New York area.

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HENRI BERGSON IS DEAD

Of interest to all whose work touches on the field of psychology, is the death of Henri Louis Bergson, greatest philosopher of modern France, in German-occupied Paris on January 4. He was 81 years old.

Son of a Jewish immigrant from Poland to France and of an English woman, Bergson—who was intensely proud of his derivation—refused, a few weeks before his death, the offer of Marshal Petain to exempt him from restrictions imposed on Jews in Nazi-dominated France.

Student of philosophy and psychology, Bergson attained commanding eminence in this field early in this century. In "Creative Evolution," written in 1907, he expounded his theory of the "élan vital," or life-urge, a universal force and all-embracing impetus behind life. His theories aroused tremendous controversy at the time he advanced them; and they have had wide influence on some current schools of psychology.

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DEATH OF LORD BADEN-POWELL

Lord Baden-Powell of Gilwell, Chief Scout of the World and founder of the Boy Scouts, died in Nyeri, Kenya Colony, Africa, January 8, at the age of 83. His revolutionary idea evolved from a single troop The movement was intended to provide a wide range of healthful activities for normal boys, when the Boy Scouts were formed by Lt. Gen. Sir Robert Baden-Powell in 1908; and the organization has long been recognized as of value in community social work. In recent years the Boy Scouts and their companion association, the Girl Scouts, have been useful as important therapeutic agents in the New York State institutions for mental defectives and in Craig Colony. In the death of Lord Baden-Powell, psychiatry loses a layman friend who made an unusual contribution to the technique of treating mentally defective and problem children.

DR. JAMES M. O'NEILL DIES

Dr. James M. O'Neill, neuropsychiatrist, who for 20 years had been resident physician at St. Vincent's Retreat, a Catholic institution for nervous and mental cases at Harrison, N. Y., died in a Port Chester hospital, after a brief illness, on January 5. He was 61.

Dr. O'Neill began his career in the State service, interning at St. Lawrence State Hospital after his graduation in medicine at McGill University in 1903, and later serving on the staff of the Hudson River State Hospital at Poughkeepsie.

Dr. O'Neill did psychiatric work in France as an officer of the American Expeditionary Force and later was consulting psychiatrist at several New York City hospitals. He leaves his wife, the former Anna Day of Morristown, N. Y., and a son, who is a student at Princeton.

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ST. ELIZABETHS SOCIETY MEETS

The Medical Society of St. Elizabeths Hospital, Washington, D. C., met and installed officers for the current year on October 22. They are: Dr. Ralph J. Haws, president; Dr. Irma Belk Hobart, vice-president; and Dr. Manson B. Pettit, secretary-treasurer.

The program included a "Discussion of Psychiatric Problems Concerning Military Conscription," by Capt. Dallas G. Sutton, U. S. N., Lt. Col. William C. Porter, U. S. A., and Dr. Harry Stack Sullivan.

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MEETINGS OF INTEREST

Medical meetings of interest to workers in the field of mental and nervous disease include the forthcoming session of the American Orthopsychiatric Association, a society for the study and treatment of behavior and its disorders, at the Hotel Pennsylvania, New York City, February 20, 21 and 22.

Another conference of national importance was the first annual medical meeting of The National Foundation for Infantile Paralysis in New York City in November. Notes on these meetings appear in the January PSYCHIATRIC QUARTERLY.

DEATHS OF DR. SCHILDER AND DR. COOK

The PSYCHIATRIC QUARTERLY SUPPLEMENT notes with regret the accidental death on December 8 of Dr. Paul Schilder, internationally known figure in psychiatric and psychoanalytic circles, and the death on October 25 of Dr. Robert G. Cook, for many years the principal owner of Brigham Hall Hospital in Canandaigua. Biographical notes on Dr. Schilder and Dr. Cook appear in the January PSYCHIATRIC QUARTERLY.

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WORK OF THE COMMONWEALTH FUND

The Commonwealth Fund has just reported the expenditure during the last year of some $2,000,000, mostly in the field of medical reasearch in America, but with some diversion for the aid of war sufferers in Great Britain and Finland. The fund is supporting 35 inquiries in institutions in the United States and maintaining 17 fellowships for advanced medical study. A large number of its recent publications have been devoted to various aspects of psychiatric social work.

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A NEW MEDICAL MAGAZINE

A new journal, "Medical Care," devoted to research and discussion of "the economic and social aspects of medicine," has made its appearance. Published as a non-profit enterprise by the Committee on Research in Medical Economics, it promises to contribute much to professional and public interest in its broad field—a subject, of course, in which the economic and social aspects of psychiatry and psychiatric social work are included.

MINUTES OF THE QUARTERLY CONFERENCE

DECEMBER 21, 1940

The Quarterly Conference of the State institution visitors and superintendents with the Commissioner of Mental Hygiene was held at the New York State Psychiatric Institute and Hospital, New York, N. Y., December 21, 1940, with Commissioner William J. Tiffany in the chair.

The large attendance included members of the Institute staff and many invited guests. Among those present, were several members of the staffs of the New Jersey state hospitals, Dr. Victor Hugh Vogel, assistant chief, Division of Mental Hygiene, United States Public Health Service, and the late Dr. James M. O'Neill, physician in charge at St. Vincent's Retreat in Harrison.

THE CHAIRMAN: Will the Conference please come to order? We are very glad to have the opportunity to meet here again with Dr. Lewis and his staff. I think the program which has been arranged is an excellent one, and as it is long and the different subjects to be presented will probably elicit considerable discussion, I think we will proceed immediately with it. First, we would like to hear from Dr. Lewis.

DR. LEWIS: It is a satisfaction to see so many of you here today. It is always a pleasure for us to have this, which might be called the annual quarterly conference, held at the Psychiatric Institute. It gives us an opportunity to renew our contacts, to exchange ideas and to have a little social activity on the side, and also to have a number of guests in addition to the more official group, guests who are interested in the promotion of social and psychiatric work, and human welfare.

We have a number of things, various researches, going on here at the Institute laboratories, as you all know. If there is anything in the building of a special nature, or of a general nature that any of you would like to see or talk about, I am sure the members of the staff will be glad to come forward and show you around. After the conference is over, the program completed, and the reports all made, I trust you will stay to luncheon with us. We will have lunch about 1 o'clock, immediately after the session. I bid you all welcome and hope you have a pleasant time.

THE CHAIRMAN: Thank you, Dr. Lewis. We do not need your assurances of welcome. I am sure everybody will be stimulated by being at the Institute. I will call upon you again, Dr. Lewis, to give the review of the research work in the Institute for the year 1940.

(Dr. Lewis read his paper.)

THE CHAIRMAN: I am sure we are all very much stimulated by such a report from Dr. Lewis of the activities that have been going on here in the Institute during the last year and more. The number is so large that it is obvious that Dr. Lewis cannot go into detail about the techniques and all the things that are involved. He did not tell you that the complete report will be published and that will give us time to read it over and study it and I am sure we will be even more enthusiastic about the valuable work that is going on here than we are this morning.

Is there any member of the Conference who cares to discuss any of the various things Dr. Lewis has reported on?

DR. CHENEY: Mr. Commissioner and members of the Conference: I think we all appreciate how difficult it is to present a concise, and at the same time, interesting and nontechnical report of activities of the Institute, such as Dr. Lewis has given us this morning. I would like to emphasize and corroborate what he said regarding the difficulty in the study of the brain chemistry of persons with mental diseases because of the lack of precise previous information regarding the normal brain chemistry.

Some of you recall that some time before 1917 an effort was made to have a chemist on the Institute staff who had had especial training in brain chemistry, investigate the brain chemistry of the alcoholic psychoses. Much time and effort was spent in that study and something was gotten out of it, but, as Dr. Lewis has indicated this morning, the difficulty at that time was, and still is, that few, if any, standard norms, have been determined for the brain. I feel, therefore, that Dr. Lewis and his staff are carrying on a very worthwhile project in attempting this very difficult problem of the study of normal brain chemistry. There are so many varients, so many things that have to be considered, that the progress is difficult, but it is work that must be done by someone if we are eventually able to evaluate chemical brain studies in mental disorders.

THE CHAIRMAN: When Dr. Lewis spoke of that work, it occurred to me that perhaps in spite of the immense amount of work a study of that kind involves, it might be well to follow up any leads that one had accumulated, as Dr. Cheney mentioned in Korsakow's psychosis and alcoholism. Quite a little work has been done in dementia præcox. It might be well to carry on, if possible, some studies of pathological material so that there would be an accumulation to compare with what is thought to be normal tissue.

Is there any further discussion? If not, we will express our thanks to Dr. Lewis and our appreciation of the immense volume of work which has been done so well and go on to the next subject on the program, which is entitled "Metrazol as an Adjunct in the Treatment of Mental Disorders"

by Dr. Clarence O. Cheney, Dr. Donald M. Hamilton and Dr. W. Lynwood Heaver. Dr. Cheney will present the paper.

(Dr. Cheney read his paper.)

THE CHAIRMAN: Dr. Cheney, we are very grateful indeed to you for this excellent presentation, and I think it may well induce us to continue this treatment where we are using metrazol, and perhaps start using it where it has been discontinued, or where it has not been used at all. It is certainly very gratifying to obtain results of this kind after the experiences we have had and the accidents that have occurred in the use of metrazol.

In the discussion which may follow I would like to hear those who have had experiences with the use of the metrazol therapy discuss the techniques or doses that they have used as compared with what Dr. Cheney has stated.

DR. CHENEY: Dr. Hamilton and Dr. Heaver are both here; they have done the work, they deserve the credit and will be glad to answer questions better than I can.

THE CHAIRMAN: Are there questions? There must be questions and discussion.

DR. BELLINGER: I have listened with interest to Dr. Cheney's paper. At the Brooklyn State Hospital, treatment of 770 patients with metrazol has been completed during the past two and one-half years. While the results we have obtained are good, they do not compare favorably with those obtained by Dr. Cheney. I am of the opinion that there are several reasons for this: First, I believe we have had a different type of patient; in other words, it is reasonable to assume that our patients do not have as good a constitutional and intellectual makeup as do those treated by Dr. Cheney. Then again, we are called upon to treat patients who have been ill for long periods. Relatives demand that patients have treatment, and I feel it is our duty to comply with requests, in the hope that some will recover. Some of our patients who have been ill but a short time, respond very favorably to metrazol and after six or eight doses appear to be in very good mental condition. However, as a rule, we treat the more advanced cases with metrazol; and I am of the opinion that it requires more than six or eight doses —often between 20 and 25 doses—before any appreciable improvement is noted. Many of our patients who receive metrazol have been ill for some months and are looked upon as unfavorable cases. However, during the past fiscal year, 153 patients were treated with metrazol, of which 48, or 31.3 per cent were away from the hospital at the end of the year; and 95, or 62 per cent, showed definite improvement. I am of the opinion that many of these patients would never have been able to leave the hospital had they not received metrazol treatment.

We still believe that the administration of metrazol causes a disturbance of calcium metabolism. All of our patients receive calcium gluconate and cod liver oil for a period of 10 days prior to the administration of metrazol; and this is continued during the treatment. At first we made no X-ray examinations of the osseous system of our patients before treatment. After we had treated several hundred patients and learned of the difficulties encountered in other hospitals, we X-rayed the spines of 100 of our patients and found that of this number 21 per cent showed compression of one or more of the vertebrae. In many patients the bodies of the vertebrae appeared to be decalcified and, in some of the cases, there was also evidence of cystic decalcification of some of the larger bones, particularly the hip bones.

Of all the patients treated with metrazol, only one appeared to suffer any discomfort as a result of injury to the vertebrae. We now find evidences of compression in some cases before metrazol is administered, which leads me to believe that some of the compressions we originally found were either congenital or the result of previous injury from which the patient had recovered and, therefore, suffered no symptoms. In addition to cases of dementia præcox, we have treated involutional psychoses; and our results with these have been gratifying. Up to the present time, no cerebral accidents or serious injuries have resulted from the treatment of involutional cases. We have had some good results with psychoneurotic patients. One man who had been in the hospital for approximately three and one-half years, whose diagnosis was psychoneurosis, psychasthenic type, with some schizophrenic manifestations, whose prognosis was looked upon as hopeless, after receiving 18 or 20 metrazol treatments, made a good recovery, was paroled, and obtained a position at the World's Fair where he earned $55 a week as an inspector of currency. After the fair closed, he was able to obtain the position which he formerly held in one of the large banks in the city. Some months ago, he came to the hospital and was presented at a meeting of one of the local medical societies. At this time, he described his mental illness and the suffering which he experienced because of his obsessions and compulsions. He attributed his recovery to the metrazol treatment; appeared to be in good mental health and showed no traces of his former psychosis.

THE CHAIRMAN: Is there other discussion?

DR. POLITAN: In response to the first question, I can say that we have observed these organic reactions in metrazol-treated patients at the Psychiatric Institute and have studied the reaction with the electroencephalogram. We have observed in patients who have memory defects, where the electro-

encephalogram was definitely abnormal, that in time—in two, three or four weeks—when the clinical picture cleared, the brain waves returned to normal; and we could consequently say that the reaction was reversible and that no permanent defect was detectible.

In regard to the technique, we initiated the strapping of the pelvis and placed the wedge-shaped pillow under the back to produce good hyperextension. With this very simple technique we found, too, that there was a marked reduction in the number of fractures, but not a complete elimination.

I was particularly interested in the number of fractures found on routine X-ray examination. When we reported our last series we had not been doing routine X-rays at the beginning, although, when aware of complications, we did examine the spines in a small group of patients prior to treatment. We did not see any abnormality in the spines before therapy was initiated. One can see in Dr. Cheney's cases that the vertebral pathology was due to previous injury to the spine with some residual defect, and that if the examination of the spine had not been made prior to treatment, the vertebral injury observed might have been attributed to the metrazol therapy.

Dr. Boudreau (of Twin Elms, Syracuse): May I ask one or two questions? First I wish to ask how you have handled the matter of artificial partial dentures since frequently their removal makes it difficult to hold the rubber wedge so as to avoid injury to the tongue or lips. Secondly, I would like to ask whether you have established that the fractures of the vertebral bodies are due only to "jack-knifing," or whether they may not be due to general contraction of the powerful back muscles, therefore causing vise-like fractures. One case that I have had suggests the latter possibility.

Dr. Hamilton (Westchester Division, New York Hospital): Concerning the dentures, they are taken out of the mouth before the treatment is instituted. I cannot give you an answer to your second question. We do not know whether the cause of fractures is "jack-knifing," but we think hyperextension of the spine is the biggest factor in preventing fractures.

The Chairman: Did you not think at one time, Dr. Bellinger, that there was pathology in the bony tissue of the vertebrae as a direct result of the metrazol therapy? Is there any change in your feeling about that?

Dr. Bellinger: We still believe that the administration of metrazol over a period of time is accompanied by a disturbance of calcium metabolism. The calcium in the bones of our younger patients does not seem to be as firmly fixed as in the bones of the older ones, so that in the young patients it frequently happens that the bodies of the vertebrae show a greater

degree of degree of decalcification than do those of the older ones. There seems to be an increase of calcium along the upper and lower edges of the vertebrae, a condition similar to that resulting from the toxins of tetanus. In some of these patients we have also found cystic decalcification of the hip bones and the neck of the femur.

THE CHAIRMAN: You did demonstrate that in animals—in rabbits—did you not?

DR. BELLINGER: We administered metrazol to a considerable number of rabbits which, after receiving a few doses showed decalcification of the bones similar to that found in our patients. These X-ray plates were first examined by our regular roentgenologist and later by Dr. Richard Rendich, who is director of X-ray therapy in the metropolitan hospitals of New York City.

DR. HARRIS (Psychiatric Institute): Dr. Cheney and his coworkers are to be congratulated upon their success in preventing the complications accompanying metrazol convulsion therapy. I would like to ask Dr. Cheney how frequently fractures occurred in their cases prior to the use of hyperextension. This information would help to determine whether the use of hyperextension prevented the occurrence of fractures in their cases. As Dr. Bellinger pointed out, patients treated in State hospitals might be in a poorer nutritional state than those treated by Dr. Cheney, and this might be a factor affecting the frequency with which fractures occur. We also have employed hyperextension in a manner similar to that used by Dr. Cheney. Although, as Dr. Polatin indicated, the frequency of the occurrence of fractures was reduced by this procedure, we were not so successful as Dr. Cheney in eliminating their occurrence.

Recently, the use of curare and Beta-erythroidin has been advocated as a preventative measure against fractures; and we have had some experience with the use of curare. These substances do decrease the severity of the muscular contractions and thereby prevent fractures, still, the use of them introduces an element of danger. Although we have had no fatalities from the use of curare we have seen some untoward reactions which produced some anxious moments. If fractures can be so effectively prevented by the use of hyperextension, as Dr. Cheney has indicated, then the general use of these substances will be definitely contraindicated.

THE CHAIRMAN: Is there further discussion?

DR. COHEN (Central Islip State Hospital): The administration of sodium amytal, prior to treatment, is very interesting. We noticed that those patients who had been disturbed the previous night required larger doses of metrazol to develop convulsions. Some did not have convulsions unless we eliminated the sedative the previous night.

DR. HAMILTON: I believe that some of the early statistics about fractures indicated something over 40 per cent in rather a small series. I think it has been found that the percentage of fractures is coming down. We are able at the Westchester Division because of the number of physicians and nurses to give a maximum degree of personal attention to the patient. As some elderly patients show lack of calcium before the metrazol treatment, we have to be extraordinarily careful with them. Most of the fractures we have, of course, are in the middle-aged group, but more important than age is the peculiar spinal configuration.

THE CHAIRMAN: The discussion very well demonstrates the reaction to your paper, Dr. Cheney, and we certainly appreciate it, and feel that it will renew our interest in the question of metrazol therapy.

Do you care to make any closing remarks?

DR. CHENEY: In regard to Dr. Bellinger's comment about the patients being of a different type, I would say they are in certain respects of education and background; but as for their mental illnesses I feel that our patients are much the same as those I saw for many years in the State hospitals. Mental patients are much the same wherever one finds them.

Regarding duration of illness before treatment, two-thirds of our patients had been sick a year before being treated, one-third of them for more than two years and up to 10 years, so they were not all by any means acute cases.

We had one man in the hospital in a catatonic state for six years; every effort, including insulin, had been made to change his condition. He had nothing to do with anybody, rarely spoke; but after three doses of metrazol he was a changed person and within a week of the beginning of the treatment he was such a social person that whereas before he had never been to one of our social gatherings, he attended a dance and was acting in a very acceptable manner. That is an example of what may occur in what appeared to be a rather hopeless long-standing case. To be sure marked improvement was not long maintained but he remained improved over his condition previous to treatment. We have treated him during the last year more than three or four times and still he is much better than he was a year ago. He is not well, perhaps he will not get well, but his mother is gratified, and something has been gained.

DR. BELLINGER: How much time is allowed to lapse between the series of treatments?

DR. CHENEY: Several weeks. I can answer Dr. Harris' question. We used no metrazol before we gained the benefit of your experience at the Institute.

THE CHAIRMAN: Time passes. I think we had better proceed with the next subject on the program which is entitled, "Electric Shock Therapy in Mental Diseases," by Dr. S. Eugene Barrera and Dr. Lother Kalinowsky.

(Dr. Barrera gave an address illustrated by lantern slides. He will prepare a paper for publication when his studies are more nearly complete.)

THE CHAIRMAN: We have received a good many inquiries from various institutions regarding the possibility of the use of this method of therapy and I am very glad that this Conference presents an opportunity for Dr. Barrera, Dr. Kalinowsky and Dr. Horwitz to demonstrate it and talk about it so that those who have inquired and wondered regarding its availability in our various institutions may have an opportunity to ask questions about it.

This very enlightening presentation is now open to the Conference for discussion.

Does any one care to discuss it?

DR. WORTHING: We were fortunate enough to have Dr. Kalinowsky attached to our staff, and treatments began at the Pilgrim State Hospital as of November, 1940. So far, we have had treated some 35 patients, and 700 applications of the treatment have been given. Of course, it is too short a time ot draw any conclusions, but certain observations have been made.

It would seem in the manic-depressive and involution melancholia group the recovery time is reduced somewhat. However, we cannot prove this. We have too few cases to draw any conclusions.

I have been fortunate enough to make an arrangement with Dr. Bowman so we will have a larger percentage of the manic group sent to Pilgrim.

At the present time we are gathering together a large number of patients who suffer from dementia præcox, a group showing much deterioration with disturbed and destructive episodes, the type of patient who breaks the furniture and windows and for whom the hope of recovery has been nil.

We hope to try the treatment on these patients in an effort to determine whether behavior problems in a class of this kind can be improved. Certainly if the destructive tendencies can be reduced and the patients can be cared for more easily, it will be an economic advantage.

DR. STECKEL: I was interested in the classification of these groups. On the one hand we have psychoneurosis, involution melancholia and dementia præcox; and in the electrical series we have the manic-depressives coupled with involution melancholia. Does that mean anything from the diagnostic standpoint?

We at Syracuse, feel that the involution psychoses are closely allied to dementia præcox, yet this would indicate they may be allied to the manic-

depressive psychoses, and all groups respond equally well to shock therapy.

DR. EPSTEIN (Pinewood, Katonah): The electrodynamics of the convulsion due to this new method are of course very important. Dr. Barrera in his talk emphasized the difference in potential between the electrodes. This of course means the driving power or the voltage necessary for the current to pass through one electrode to another by way of the brain. I think evidence is beginning to accumulate that there are reversible and irreversible reactions in the brain as a result of these currents and we must realize that it is the amount of the current rather than the voltage which probably is the most important factor.

Bini in his original paper which he read in 1937 at the Swiss Psychiatric Association Conference in Münsingen, Berne, described his experiments in which he induced convulsions in animals by means of two electrodes, one inserted in the animal's mouth and the other in its rectum. At that conference he reported both reversible and irreversible changes in the brain tissue as a result of these convulsions.

In my experience, which has been over a considerable period of time with this type of therapy, I think that the convulsion, although it appears instantaneous, is not quite so instantaneous as might be believed. Kalinowsky, in his article in the Lancet last year, mentioned the fact that he believed the convulsion to be instantaneous and that the time factor was essentially unimportant. I have not confirmed this opinion. In other words I have found that where a given milliamperage and a given voltage will produce a petit mal seizure in 2/10ths second, all factors being equal, the increasing of the time to 3/10ths second or to 5/10ths second, will produce a very typical and complete convulsion.

I have been doing a considerable amount of this work and have an instrument which is an American modification with the emphasis on the milliamperage rather than the voltage. With this instrument, one can predetermine accurately exactly how many milliamperes one wishes to administer to the patient, and any subsequent variations in treatment can be precisely predetermined with this apparatus. The voltage is automatically set to produce the desired amount of current.

Later on as other clinics will begin to report on neuropathological findings in conjunction with this method of therapy one will not be able to evaluate the results unless common factors are used in bringing them about. In other words, there may be such a great variation in the elements of time or milliamperage administered, that the pathological end results may not be comparable.

THE CHAIRMAN: Is there further discussion of this paper?

DR. BROWN (Central Islip State Hospital): I have heard both Dr. Barrera's and Dr. Kalinowsky's presentation of this subject. In both papers, the assumption is made that the convulsive state produced by electric shock is identical to that produced through insulin and metrazol. In metrazol, I believe it is generally conceded that the shock is achieved through oxygen deprivation, while in insulin it is through hypoglycemia.

I do not believe that we understand the physiology behind electric shock, and until we do, it is an error to assume that the phenomenon is identical to that achieved by means of chemotherapy.

DR. LEWIS: In a number of patients suffering with mental disorder, the attacks are recurrent in nature, with fairly definite recoveries in between. Not only is this true of the manic-depressive types, but it is seen in the periodic expressions of schizophrenia. In any given case it is rather difficult to make a satisfactory prognosis as to the final outcome; but the fact remains that when some of these cases are treated by metrazol or electric shock, a remission is produced, and the course of the psychosis is thus cut short. If one prefers not to consider these reactions as cures, he must still admit that the disorder has been strikingly interrupted. As yet no one seems to know just how this interruption is brought about, and some seem to be fearful that there has been some killing off of the brain cells, which produces merely a shift in the picture, a slowing up of the processes, rather than actual improvement. If future histological reactions of the brain reveal a numerical reduction in the cortical cells, it is not illogical to suppose that it is the weaker, sicker cells, or those poorly nourished, that have been destroyed. It is very possible that only the poor cells which may be giving off toxins or deleterious products are being destroyed, which may be a very good thing, therapeutically, as it might allow a better functioning of the remaining cells. There have been a number of patients reported in whom definite clinical improvement with social readjustments have taken place following the new psychosurgery called "leucotomy." There is no question that this procedure destroys brain tissue, as certain areas are deliberately removed or macerated. Most of these cases are types of depression, including involutional melancholia. I am not making this statement to support any surgical procedures on the brain for the psychoses, but merely to point out that destruction of brain tissue at times seems to produce a definite shift for the better in a psychosis and to emphasize that perhaps some of this tissue may be nonfunctioning or diseased.

THE CHAIRMAN: We do that in surgery to remove objectionable tissue.

DR. LEWIS: There are many opinions as to the degree of recovery attained from a severe schizophrenic psychosis, some believing that we never

have complete recovery as there always remains some evidence of what has been called "scarring" or residuals of the psychosis. Another viewpoint which I am inclined to favor is that we get as much recovery from a psychosis as we do from practically any other severe disease in the body. The difference is just this:

When organs recover from severe infections or from degenerative diseases there always remains some scar tissue in the organ which gives evidence that a disease has at one time been present. In patients who have recovered from pleurisy for instance, there are practically always scars and remaining adhesions, etc., to mark the site of the disorder. One could give many examples of this sort of thing. When the disorder is a mental disease, unfortunately the scarring is of the nature of personality changes or deviations which may be permanent in nature, and inasmuch as one's personality adjustments are matters which show in everyday behavior, the scars, so to speak, are always in sight. The scars of nephritis from an old scarlet fever, are not in sight and one may be able to go along for a period of time with a kidney disorder without serious interference with interpersonal relationships; but, in psychiatry, if there is any residual left it shows in the behavior. Therefore, when we get a definite remission or a recovery in the form of mental disease which allows a patient to make a fairly adequate personal adjustment in society, it should be considered as a recovery in the same way that we evaluate heart disease when there is still some remnant brought out on careful examination. By and large it is the adjustment of the individual which indicates the degree of the efficacy of treatment. Undoubtedly the constitution of the individual, with these various predispositions to disorder, is still there and may sensitize the individual to future difficulties.

THE CHAIRMAN: Is there further discussion of this paper?

MR. ROGERS: Have there been any histological examinations of animals in regard to electric shock to discover whether there is any destruction of nerve tissue in the brain or nervous system as a result of the electric shock?

THE CHAIRMAN: Dr. Barrera can you answer that question?

DR. BARRERA: We do not want to go into all the details involved in this problem before a gathering of this type. Most of us are interested in the more general aspects of the problem and are neither qualified nor interested in the finer details of many of the special problems involved. In addition, many of the problems involved in this study are still extremely controversial.

With regard to the findings in animal brains, I would say that as yet there have not been any reports in the literature dealing with findings in

the brains of animals to which the treatment has been administered in a manner comparable to the way in which it is administered to human beings. In addition, to the best of my knowledge, there have been no studies on human brains as yet. There was a report by Italian authors dealing with changes in the brain of a dog which had been subjected to electric convulsions. The animal, however, was subjected to one convulsion after another and killed after several hours of these observations. It was reported that only reversible changes were found in the brain. We feel, of course, that this experiment was not in any way comparable to what we might expect to find in animals or humans subjected to electric shock treatment in the way in which it is done clinically. Many of the so-called irreversible changes, such as the blood vessel changes, would not have time to occur in such an acute experiment and therefore the results are not really comparable to our human cases.

At the Psychiatric Institute at present, in the department of psychiatry, we are administering electric shocks to monkeys with the same apparatus and under essentially the same conditions as we administer the treatment to patients. The same voltages and times and frequencies of treatment are also used. We shall make a thorough study of these brains and see what comes out.

I have also not wanted to discuss here all the questions dealing with the technical electrical aspects of the problem. Dr. Epstein imputes to me statements which I did not either make or imply. I stated simply that certain voltages were used in the production of the shock. I did not say, nor mean to say, that it was the voltage alone which was responsible for what happens in the patient. Of course there is the possibility, and even a high probability that the current and perhaps the time during which it passes are responsible to a great extent for what occurs.

THE CHAIRMAN: I am sorry that time advances and we have no opportunity to discuss further this very interesting and instructive paper as there are several other things on the program that must be covered.

It is a very appropriate time for Dr. Ross to give an appreciation of our past superintendent, Dr. Robert Woodman.

(Dr. Ross read his appreciation of Dr. Robert Woodman, pp. 133, 134, 135.)

THE CHAIRMAN: The Conference owes you a debt of gratitude for this expression and I am sure it is an expression that gives the feeling of the members of the Conference and the Department and all the friends in the Department. There is nothing I can add to this fine expression of Dr. Ross.

Next on the program are the reports of the committees. Dr. Mills, can you give a report for the construction committee in Dr. Garvin's absence?

DR. MILLS: There have been no meetings of the committee since the last Conference. As, perhaps, most of you know, Dr. Garvin has been seriously ill but I am pleased to report that I have a letter from him and he is improving very nicely.

THE CHAIRMAN: There being no report of the construction committee, no action is required on the part of the Conference.

Next on the program is the report of the committee on nursing, of which Dr. Pritchard is the chairman.

Dr. Pritchard reported the following.

REPORT OF THE COMMITTEE ON NURSING

The committee on nursing met on the evening of December 20, at the Hotel Commodore, New York City, all members being present.

Both the preceding and present chairmen of the committee on nursing had a conference with Mr. Campbell, chairman of the classification committee of the Department of Civil Service, and also with Commissioner Tiffany. As a result of these conferences and a fair amount of correspondence, progress was made toward solving some of the problems that have developed due to the position of attendant being placed in the competitive class on January 1, 1941. While all details have not been settled, it is felt that they will be arranged satisfactorily, and a working basis has been established.

The classification board and the Department of Civil Service have decided that the position of nurse will not be considered competitive at the present time. Those students who successfully complete three years of training may be appointed "provisional nurses" at attendants' pay until they obtain their R. N. certificates whereupon they will become registered nurses.

An attendant appointed from a competitive list may be assigned to the training school and, during training, will retain his or her competitive standing, being reported on the payroll as "attendant" followed by the words "Student nurse C" in brackets. The student nurses recruited from other sources will be considered noncompetitive appointments as in the past. Persons employed in anticipation of their entering the nurses' training school will be appointed and carried on the payroll as "attendant" followed by the words "Student nurse N. C." in brackets. The latter, who are noncompetitive, will thus be carried and paid the minimum wage for hospital attendant and shall receive no increase for time service up until the time

they enter the training class, when they will take their places as student nurses at $27 per month. The number of such employees is not to exceed the number normally enrolled in the training class. It is understood that the services of such persons will be terminated if they do not enter the next class formed. This procedure will meet the problem where prospective trainees are taken on over a period of several months prior to the opening of the training class. It will permit us to pay them the full salary of an attendant during the few months they are actually in that capacity and will permit of their selection on a noncompetitive basis.

In respect to contracts for affiliating students submitted by the department of hospitals, New York City, which contained a paragraph stating "Compensation should be shared by the home and affiliating schools"—These were signed and returned with this paragraph stricken out, it having been decided at a conference of representatives of the departments interested that the decision in each case should be left to the presiding referees or judges. However, the secretary of the department of hospitals, New York City, on September 30, wrote in part as follows: "I am advised by the corporation counsel that the matter has been determined by the Court of Appeals in the matter of Yvonne Proctor against Genesee Hospital and Willard Parker Hospital, and that such cases are no longer open to differing determinations by referees or inferior courts. The proposed Paragraph 17 sought to incorporate into our contract the equal distribution of compensation obligations as defined by the Court of Appeals in the above named case. We do not see how any different principle can be applied." This letter was forwarded, through the Department of Mental Hygiene, to the Department of Labor which replied on October 8, through Mr. Holland, assistant commissioner, as follows: "This is a very interesting decision and I shall communicate further with you after I have given it a little additional attention." Nothing further has been heard since that date.

When new contracts are presented for signing, if this clause is again inserted, it should be stricken out before they are signed, unless before that time different instructions are received from our Department.

If this report is accepted by the Conference a letter covering the essential points in it, will be sent to each hospital that has a training school for nurses.

Respectfully submitted,

J. A. PRITCHARD, M. D.,
Chairman, Committee on Nursing.

THE CHAIRMAN: You have heard the report of Dr. Pritchard. What is the pleasure of the Conference regarding it?

It was moved, seconded and carried that the report of the committee on nursing be accepted.

THE CHAIRMAN: The next on the program is the report of the committee on statistics and forms, of which Dr. Pollock is chairman.

Dr. Pollock read the report:

REPORT OF THE COMMITTEE ON STATISTICS AND FORMS

The committee on statistics and forms met at the Psychiatric Institute on the afternoon of December 20. Five members of the committee were present. Proposals for the modification of several forms were received and passed on by the committee. It was agreed to recommend to the Conference minor changes in the following forms:

Form 472-D. M. H., form for the regular commitment of the mentally ill.

Form 92-D. M. H., form for admission of patient to a State hospital on certificate of one physician.

Forms 131 and 190-D. M. H., forms for the commitment and admission on certificate, respectively, of the mentally defective to State schools.

Form 41-Med., form for voluntary application.

Form 56-Adm., form for service of notice on patient before commitment.

Form 103-Adm., (Ment. Def.) form for monthly report of movement of patients in State schools.

Form 22-Med., form for recording statistical data for use in case records.

Form 26-D. M. H., form for supplying data concerning a patient to the Attorney General in proposed committee cases.

Form 151-Std., form for recording salary data for income tax return.

Form 33-Std., form for record of employees' absences.

Form 34-Med., form for record of physical examination of patient.

The minor changes recommended in these forms the committee believes will make them more acceptable to everyone concerned.

The committee considered a form for reporting occupational treatment on wards and decided not to recommend it for general use.

A new form for recording condition of a patient during an operation was submitted to the committee by Dr. George W. Mills. The committee, after consideration of the form, decided to refer it to the several hospitals of the Department before recommending its adoption for general use.

Respectfully submitted,

HORATIO M. POLLOCK, Ph.D.,

Chairman, Committee on Statistics and Forms

THE CHAIRMAN: You have heard the report of the committee on statistics and forms. What is the pleasure of the Conference? Is there any discussion of this report?

The motion was made, seconded and carried that the report be accepted.

THE CHAIRMAN: Are there other committees to report at this time?

DR. ROSS: I have a report for the committee on community and family care.

(DR. ROSS read the report, pp. 108, 109.)

THE CHAIRMAN: Is there any one who cares to discuss this report? What is the pleasure of the Conference?

The motion was made, seconded and carried to accept the report.

THE CHAIRMAN: Is there any unfinished business to be taken up at this time by the Conference?

Is there any new business?

Before closing, Dr. Lewis would like to make an announcement.

Dr. Lewis explained about the luncheon and the visiting of the Institute after lunch.

The Conference adjourned.

GENERAL STATISTICAL INFORMATION RELATING TO STATE HOSPITALS, STATE SCHOOLS AND CRAIG COLONY

CENSUS OF JANUARY 1, 1941

Patient population:		
Civil State hospitals:		
In hospitals	71,762	
In family care	626	
On parole	7,557	
		79,945
Dannemora and Matteawan		2,694
Private licensed institutions for mental disease		*5,520
Institutions for mental defectives:		
In institutions proper	13,640	
In colonies	1,665	
In family care	400	
On parole	1,982	
		17,687
Licensed institutions for mental defectives		*522
Institutions for defective delinquents		1,902
Craig Colony for epileptics		2,558
Total		*110,828
Certified capacity of civil State hospitals		62,127
Certified capacity of Dannemora and Matteawan		1,791
Certified capacity of institutions for mental defectives		11,713
Certified capacity of Craig Colony for epileptics		1,990
Medical officers in civil State hospitals		400
Medical officers in Dannemora and Matteawan		14
Medical officers in institutions for mental defectives		47
Medical officers in Craig Colony for epileptics		12
Employees in civil State hospitals		16,823
Employees in Dannemora and Matteawan		830
Employees in institutions for mental defectives		2,980
Employees in Craig Colony for epileptics		507

*Subject to correction.

MOVEMENT OF EMPLOYEES IN THE CIVIL STATE HOSPITALS DURING THE SIX MONTHS ENDED DECEMBER 31, 1940

State hospitals	In service, July 1, 1940			Engaged			Left service			In service, Dec. 31, 1940			Vacancies Dec. 31, 1940			Number of patients, excluding paroles, Dec. 31, 1940, to each		
	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officer	Ward employee	Employee
Binghamton	15	388	258	2	43	21	1	24	15	16	407	264	2	4	9	170.9	6.7	4.0
Brooklyn	26	534	247	2	232	26	1	108	19	27	658	254	3	..	19	119.0	4.9	3.4
Buffalo	12	326	212	1	47	18	3	53	19	10	320	211	6	13	14	233.2	7.3	4.3
Central Islip	30	968	356	6	214	35	2	167	29	34	1,015	362	10	116	58	219.0	7.3	5.3
Creedmoor	22	646	314	5	113	54	2	98	39	25	661	329	1	4	14	179.9	6.8	4.4
Gowanda	12	322	217	2	71	16	2	72	21	12	321	212	3	4	20	198.1	7.4	4.4
Harlem Valley	21	652	293	1	118	33	1	96	31	21	674	295	3	3	6	212.1	6.6	4.5
Hudson River	25	595	400	2	165	37	2	113	31	25	647	406	3	28	9	175.4	6.8	4.1
Kings Park	34	840	453	2	149	41	3	102	43	33	887	451	..	..	..	182.4	6.8	4.4
Manhattan	19	448	340	..	31	18	1	62	25	18	417	333	..	..	..	156.3	6.7	3.7
Marcy	15	347	259	..	34	21	..	51	22	15	330	258	2	25	12	173.6	7.9	4.3
Middletown	17	484	232	..	79	20	1	74	11	16	489	241	5	33	12	207.3	6.8	4.4
Pilgrim	38	1,209	442	9	308	75	7	209	42	40	1,308	475	..	..	..	227.0	6.9	5.0
Psy. Inst. and Hosp.	12	72	156	6	21	12	3	14	10	15	79	158	4	8	7	9.1	1.7	0.5
Rochester	14	455	208	3	66	12	1	44	11	16	477	209	2	1	13	196.2	6.6	4.5
Rockland	35	925	442	3	312	37	1	248	40	37	989	439	2	35	26	188.1	7.0	4.8
St. Lawrence	13	320	228	..	63	16	3	56	14	10	327	230	6	12	12	207.2	6.3	3.7
Syracuse Psy. Hosp.	4	54	23	..	11	3	..	10	2	4	55	24	..	4	..	11.5	0.8	0.6
Utica	11	256	220	4	57	11	3	48	16	12	265	215	1	21	18	153.1	6.9	3.7
Willard	12	437	291	2	43	17	..	43	14	14	437	294	3	10	14	208.9	6.7	3.9
Total	387	10,278	5,591	50	2,177	523	37	1,692	454	400	10,763	5,660	56	321	263	189.5*	6.8*	4.4*

*Excluding Psychiatric and Syracuse Psychopathic Hospital.

MOVEMENT OF PATIENTS IN THE CIVIL STATE HOSPITALS DURING THE SIX MONTHS ENDED DECEMBER 31, 1940, AS REPORTED BY SUPERINTENDENTS, AND STATEMENT OF CAPACITY AND OVERCROWDING DECEMBER 31, 1940

State hospitals	Census, July 1, 1940	Admissions				Discharges								Census, Dec. 31, 1940	Certified capacity	Overcrowding	
		First admissions	Readmissions	Transfers	Total	Recovered	Much improved	Improved	Unimproved	Not insane	Died	Transferred	Total			Number	Per cent
Binghamton	2,965	195	59	3	257	41	41	32	11	9	117	2	253	2,969	2,391	305	12.8
Brooklyn	3,695	1,101	225	6	1,332	183	129	97	22	..	434	59	924	4,103	2,603	610	23.4
Buffalo	2,596	212	52	13	277	42	37	39	15	2	92	13	240	2,633	1,942	390	20.1
Central Islip	7,826	654	200	10	864	156	147	38	30	2	226	8	607	8,083	5,943	1,407	23.7
Creedmoor	4,974	442	115	13	570	120	58	40	7	4	199	27	455	5,089	3,904	593	15.2
Gowanda	2,691	194	52	11	257	67	25	19	8	9	104	8	240	2,708	2,228	112	5.0
Harlem Valley	4,761	209	59	7	275	45	38	26	5	2	120	14	250	4,786	3,972	404	10.2
Hudson River	4,717	175	106	10	291	74	28	49	14	13	180	13	371	4,637	4,014	323	8.0
Kings Park	6,768	373	127	87	587	122	173	48	27	..	177	61	608	6,747	4,986	1,029	20.6
Manhattan	3,371	417	65	..	482	173	65	42	9	..	296	150	735	3,118	2,813	..	..
Marcy	2,848	241	68	12	321	46	61	42	12	17	103	10	291	2,878	2,140	426	19.9
Middletown	3,538	110	55	30	195	41	31	24	15	4	98	..	213	3,520	2,780	422	15.2
Pilgrim	9,590	716	125	27	868	226	62	17	14	3	312	34	668	9,790	7,831	1,226	15.7
Psy. Inst. and Hosp..	126	128	26	3	157	31	29	26	28	12	1	2	129	154	210	—73	..
Rochester	3,395	198	57	5	260	43	39	17	8	10	130	9	256	3,399	2,750	367	13.3
Rockland	7,445	774	203	132	1,109	117	143	115	44	10	230	20	679	7,875	5,768	1,191	17.1
St. Lawrence	2,244	150	33	1	184	72	13	27	10	2	78	3	205	2,223	1,721	315	18.3
Syracuse Psy. Hosp..	50	231	91	..	322	57	30	41	31	43	5	119†	326	46	60	—14	..
Utica	2,083	201	55	1	257	52	52	34	16	20	95	9	278	2,062	1,552	219	14.1
Willard	3,131	132	45	1	178	26	19	16	2	4	111	6	184	3,125	2,519	383	15.2
Total	78,814	6,853	1,818	372	9,043	1,734	1,220	789	328	166	3,108	567	7,912	79,945	62,127	9,722*	15.7*

*Excluding Psychiatric Institute and Syracuse Psychopathic Hospital. †Committed to other institutions.

Movement of Employees in the State Institutions for Mental Defectives and Epileptics During the Six Months Ended December 31, 1940

State institutions	In service, July 1, 1940			Engaged			Left service			In service, Dec. 31, 1940			Vacancies, Dec. 31, 1940			Number of patients, excluding paroles, Dec. 31, 1940, to each		
	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officers	Ward employees	Other employees	Medical officer	Ward employee	Employee
State Schools for Mental Defectives:																		
Letchworth Village	12	499	204	2	90	18	2	71	18	12	518	204	4	8	9	339.3	7.9	5.5
Newark	7	288	177	2	36	15	1	23	18	8	301	174	1	17	10	327.4	8.7	5.4
Rome	8	493	203	1	50	15	..	46	14	9	497	204	5	22	15	388.8	7.0	4.9
Syracuse	5	132	131	1	8	12	..	8	13	6	132	130	..	4	8	166.5	7.6	3.7
Wassaic	12	521	224	..	160	18	..	129	21	12	552	221	1	3	13	376.4	8.2	5.8
Total	44	1,933	939	6	344	78	3	277	84	47	2,000	933	11	54	55	334.1	7.9	5.3
Craig Colony for Epileptics	12	282	208	1	42	9	1	35	11	12	289	206	1	21	13	191.4	8.0	4.5

MOVEMENT OF PATIENTS IN THE STATE INSTITUTIONS FOR MENTAL DEFECTIVES AND EPILEPTICS DURING THE SIX MONTHS ENDED DECEMBER 31, 1940, AS REPORTED BY SUPERINTENDENTS AND STATEMENT OF CAPACITY AND OVERCROWDING ON DECEMBER 31, 1940

State institutions	Census, July 1, 1940	Admissions				Discharges							Census, Dec. 31, 1940	Certified capacity	Overcrowding in institutions	
		First admissions	Readmissions	Transfers	Total	Improved	Unimproved	Not mentally defective	Not epileptic	Died	Transferred	Total			Number	Per cent
State Schools for Mental Defectives:																
Letchworth Village	4,376	206	19	4	229	73	43	36	..	16	2	170	4,435	3,178	764	24.0
Newark	3,118	115	13	3	131	45	43	..	..	16	2	106	3,143	1,874	367	19.6
Rome	3,869	125	11	1	137	69	33	..	..	17	2	121	3,885	2,440	16	0.7
Syracuse	1,393	54	2	..	56	43	2	..	..	4	..	49	1,400	677	—86	..
Wassaic	4,742	227	24	7	258	116	25	7	..	28	..	176	4,824	3,544	866	24.4
Total	17,498	727	69	15	811	346	146	43	..	81	6	622	17,687	11,713	1,927	16.5
Craig Colony for Epileptics	2,561	136	14	..	150	46	48	..	..	59	..	153	2,558	1,990	307	15.4